Ihosvani Miguel, MD, PA

Endo Care of South Florida
Center for Endocrine and Diabetes Care

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New Patient Registration Form

Today's Date			
Full Legal Name (First)	Middle:	Last:	Other name used (i.e Maiden Name
Address:		City, State, Zip	
Email address:	Home phone no:	Cell phone no:	Social Security no:
Date of Birth	Ocupation:	Employer:	Employer phone no:

To comply with goverment reporting, please mark which applies:

Ethnicity ☐ Hispanic/Latino ☐ Other

Race ☐ White ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ American Indian/Alaska Native

Language: ☐ English ☐ Spanish ☐ French ☐ Other

Your Primary Doctor	Office Phone Number	Office Fax Number	Addresss
Your Pharmacy	Phone Number	Address	

INSURANCE INFORMATION

Primary Insurance Company Name	Group No.	ID/Certificate No.
Subscriber Name:	Subscriber's Birth date:	
Secondary Insurance Company Naqme	Group No.	Group No.
Subscriber Name:		
Other Insurance Information		

EMERGENCY INFORMATION

Name of local relative or friend :	Relationship to patient	Home phone no.:	Cell no.

MAY WE CONTACT YOU?

I wish to be contacted in the following manner :

Primary Phone: _____

Email Address: _____

Other: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Endo Care of South Florida and/or, Ihosvani Mlguel, MD, PA or insurance company to release any information required to process any claim.

Patient/Guardian signature:_____

1. How often do you exercise on average week?

☐ 0-2 days ☐ 3-5 days ☐ 6-7 days

2. Duration of your exercise/walk/biking per session?

☐ 0-30 Min ☐ 31-60 Min ☐ More than 1 hr.

3. Describe your diet (what you eat on a daily basis

4. Do you presently smoke/use tobacco?

◯ Yes ◯ No How many packs a day?

5. Have you ever smoked?

◯ Yes ◯ No Whed did you quit?

6. Do you currently consume more than 2 alcohol drinks a day?

◯ Yes ◯ No

I need to see Endocrinologist for :

7. I have the following medical conditions

1. _____
2. _____
3. _____
4. _____
5. _____

8 .I had the following surgeries or was hospitalized for:

1. _____
2. _____
3. _____

9. I'm allergic to the following medications:

	Medication	Allergic Reaction
1.		
2		
3.		

Date of Last Physical Exam (month/year)_____

Date of Last Eye Exam (Month/Year_____

Date of Last Foot Exam (Month/Year)_____

Date of Last Dental Exam (Month/Year)_____

10. I Am taking the following medicines, vitamins, supplements, herbs (name, dose, frequency):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7 _____
8. _____
9. _____
10. _____

Family History

11. Do your parents or brothers/sisters/children have or had (*Circle all that apply):*

a. Heart attack/Heart Bypass surgery/Stent : Yes No Don't Know

b. Stroke? Yes No Don't Know

c. High Cholesterol? Yes No Don't KNow

d. Obesity? Yes No Don't Know

e. Adult Diabetes? Yes No Don't Know

f. Juvenile, Type 1 Diabetes? Yes No Don't Know

g. Thyroid Disease? Yes No Don't Know If yes, what kind? _____

h. Cancer? Yes No Don't Know If yes, what organ did it start? _____

i. Osteoporosis, Hip fracture? Yes No Don't Know

j. Rheumatoid Arthritis, Lupus, Multiple Sclerosis, ALS? Yes No Don't Know

Reason for Visit:

Please mark any of the following symptoms that you are having:

General: ☐ Unexplained weight change ☐ Fatigue ☐ Fever

Eyes: ☐ Eye Laser Treatment ☐ Cataracts ☐ Retinal Detachment ☐ Poor Vision/Blindness ☐ Glaucoma

Ent.: ☐ Changes in Voice, Hoarseness ☐ Difficulty Swallowing ☐ Enlarged Thyroid or Neck Lumps ☐ Pain in Front of the Neck

Heart/ Respiratory: ☐ Asthma or CORP ☐ Sleep Apnea ☐ Shortness of breathon Exertion ☐ USE CPAP/BIPAP ☐ Slow, Fast, or Irregular Heart Beat
☐ Short of Breath at Night/Rest ☐ Ankle/Leg Swelling ☐ Pacemaker or Internal Deibrillator ☐ Long Term Cough
☐ Poor Healing Leg Ulcers

Gastrointestinal: ☐ Nausea/Vomiting ☐ Frequent Heartburn, Indigestion ☐ Irritable Bowel ☐ Diarrhea or Constipation ☐ Food intolerances:

Breast: ☐ Nipple Discharge ☐ Breast Pain/Tenderness or Swelling

Blood: ☐ History of Blood Clots ☐ Bleeding Problems ☐ Easy Bruising
Have you ever had radiation treatments to head, neck or whole body? ◯ Yes ◯ No

Urological: ☐ Frequent Bladder or Vaginal infections ☐ Frequent Urination ☐ Kidney Stones

Men Only: ☐ Pain or Lump in Testicles ☐ Change in desire to have sexual intimacy (libido) ☐ Difficulties achieving or mantaining erection

Women Only: ☐ Irregular Periods ☐ Vaginal Dryness ☐ Date of Last Period: ☐ Are you currently pregnant? ◯ Yes ◯ No

Musc/Bones: ☐ Gout ☐ Arthritis ☐ Fractures ☐ Amputations

Neuro/Psych: ☐ Frequent Severe Headaches ☐ Unsteady Gait ☐ Dizziness ☐ Previous Head Injury ☐ Loss of Consciousness
☐ Memory Loss ☐ Seizures ☐ Tremor ☐ Depression/Anxiety/Fears ☐ Paralisis ☐ Decreased Sensation/Feet

Endocrine: ☐ Excessive Sweating/Night Sweats ☐ Thyroid Problems ☐ Pituitary Problems ☐ Calcium Problems
☐ Low Blood Sugar ☐ Heat/Cold Intolerance

Skin: ☐ Foot Leg Ulcer ☐ Skin Rash ☐ Hair Loss ☐ Darkening or Lightening of Skin ☐ Dry Skin

Anything else you would like us to know about you? _____

I hereby certify that the answers given are true and complete to the best of my knowledge. I hereby authorize Endo Care of South Florida and/or Ihosvani Miguel, MD, PA to release any information acquired in the course of my treatment to any physician or health organization as required.

Signature: _____

Vitals

Temp: _____ HT: _____

Pulse _____ WT: _____

Resp _____ BP: _____

For office use only: _____

Reviewed: _____

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Acknowledgment Form of Endo Care of South Florida

Patient's Name_____ Date of Birth ____/____/_____

Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also requires to obtain your signature acknowledging that this notice has been made available to you.

Signature: _____ Date: _____

(Patient or Authorized Representative)

Relationship to patient:____Self_____Spouse_____Other

Reason Patient Unable/Unwilling to Sign:_____

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Cancellation Policy

Please keep in mind that the office of Dr. Miguel holds a 24 hours cancellation policy.

If you fail to cancel or reschedule your appointment with a minimum of 24 hours prior to your scheduled time, a $50 fee will apply.

The office provides you with appointment reminders through a courtesy call 48 hours prior to your appointment to avoid this fee being added to your account. Nevertheless, it is your responsibility to cancel or reschedule your appointment with 24 hours notice.

Signature:_____

Thank you

Dr. Ihosvani Miguel