Capitol Endocrinology Inc.
3106 Ponte Morino Drive, Suite C
Cameron Park, CA 95682
Tel (530)677.0700
Fax (530)676.7850
www.capitolendo.com

NEW PATIENT INFORMATION

Welcome to our office! We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally. Through our health care experience we strive to meet your medical needs and exceed your expectation with courteous, attentive, personal care.

Please find enclosed new patient forms which include a Registration form, Medical history questionnaire, Notice of privacy and financial policy. In order to save time, please fill these forms out and bring them with you to your first visit along a list of medications you take at this time including calcium, vitamins and herbs.

Please arrive 30 minutes prior to your scheduled appointment time. It is important that you remember to bring your current insurance card and driver's license at every visit. Your co-payment and / or deductible is always due at the time of your visit. If you are unable to keep your appointment, please give us 48 hours notice so we can accommodate other patients on the waiting list.

Please do not hesitate to call our office with any questions.

We look forward to meeting you.

Sincerely,

Jaiwant Rangi, MD, FACE and Staff

DIRECTIONS TO OUR OFFICE

FROM SACRAMENTO
Take Hwy 50 East towards Lake Tahoe. Exit at Cameron Park Drive. Make a left onto Cameron Park Drive. Turn right on Palmer Drive. Turn left on Ponte Morino Drive. Take the second driveway on the left into the Palmer Professional Center. We are in building # 3106, Suite C.

FROM LAKE TAHOE
Take 50 West towards Sacramento. Exit at Cameron Park Drive. Turn right on Cameron Park Drive. Turn right on Palmer Drive. Turn left on Ponte Morino Drive. Take the second driveway on the left into the Palmer Professional Center. We are in building 3106, Suite C.

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REGISTRATION FORM

SECTION I: PATIENT INFORMATION				
PATIENT NAME	DATE OF BIRTH	HOME PHONE		
ADDRESS		CITY	STATE	ZIP
SOCIAL SECURITY NO	OCCUPATION	EMPLOYER		
ADDRESS		CITY	STATE	ZIP
LOCAL PHARMACY	PHONE	FAX		
MAIL ORDER PHARMACY	PHONE	FAX		
EMERGENCY CONTACT	PHONE	RELATIONSHIP		
SPOUSE´S NAME	ADDRESS	CITY	STATE	ZIP
OCCUPATION	EMPLOYER	PHONE		
REFERRING PHYSICIAN		PHONE		
SECTION II: HEALTH INSURANCE INFORMATION				
PRIMARY INSURANCE	SUBSCRIBER ID #	GROUP#		
SUBSCRIBER´S NAME	RELATIONSHIP TO PATIENT	CONTACT PHONE#		
SECONDARY INSURANCE	SUBSCRIBER ID#	GROUP#		
SUBSCRIBER´S NAME	RELATIONSHIP TO PATIENT	CONTACT PHONE #		

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS: The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance which will be collected at the time of initial or follow up visit. I also authorize Capitol Endocrinology Inc. / Jaiwant Rangi, MD, FACE or insurance company to release any information required to process my claims. In the event you are required to proceed with any collection proceedings, I shall additionally be responsible for all reasonable fees associated with the collection of my debt and interest on the outstanding balance. I understand that it is the policy of this office to charge $25 fee for any returned / bounced checks or cancellation less than 48 hours of visit and no show. I have reviewed the detailed financial policy for Capitol Endocrinology Inc.

Patient / Guardian Signature Date: _____ Date: _____

AUTHORIZATION OF MEDICAL RECORD RELEASE: I authorize the release of my medical records to Capitol Endocrinology Inc. / Jaiwant Rangi, MD, FACE and also authorize Dr.Rangi to release my medical records by Capitol Endocrinology Inc. / Jaiwant Rangi, MD, FACE to other physicians/ Institutions for continued medical treatment and help manage my medical condition.

Patient / Guardian Signature Date: _____ Date: _____

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FINANCIAL POLICY

1. We accept most insurance plans. Please call us if you have any specific questions.

2. Payment is due at the time of services unless arrangements have been made in advance by your Carrier. We accept cash, checks, money orders and most major credit cards.

3. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As service to you, we will file your insurance claim if you assign benefits to your doctor in other-words, if you agree to have your insurance company pays the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

4. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them and you are required to pay a co-payment at the time of your visit.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

6. Our billing company will send monthly statements to inform you of any balance due. We expect that patients due balances will be paid upon receipt of our statement. Any remaining unpaid balance will be collected at the time of your next visit. You also have the option to pay over the phone. Should there be an issue with your ability to pay, we encourage you to contact our billing service and arrange a payment plan for your balance due.

7. If necessary, unpaid past due accounts will be forwarded to an outside collection agency. All cost of this process will be your responsibility.

8. Our billing professionals will do all they can to communicate with you and your insurance company to resolve any issues. Questions regarding billing issues can be directed to our professional billing office at 1-866-949-4565 (Toll free)

9. I understand that it is the policy of this office to charge $25 fee for any returned / bounced checks or cancellation less than 48 hours of visit /no show.

10. I have read and understand the practice's financial policy and I agree to bind by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Name of patient _____ Date _____

Signature of patient (or responsible party, if minor) _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you (as a patient of our practice) may be used and disclosed, and how you can get access to your health information. This is required by the privacy regulations created as a result of the health insurance portability and accountability act of 1996 (HIPAA).

OUR COMMITMENT TO YOUR PRIVACY: Our practice is very dedicated to maintaining the privacy of your health information. Additionally, we are required by law to maintain the confidentiality of your health information. We realize these laws are complicated, but we are obligated to provide you with the following important information. Use and disclose of your health information in certain special circumstances- common rule of law.

THE FOLLOWING CIRCUMSTANCES MAY REQUIRE US TO USE OR DISCLOSE YOUR HEALTH INFORMATION:

1. To public health authorities and health oversight agencies that are authorized to collect information.
2. Law suits and similar proceeding in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent serious health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military force (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institution or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For workers compensation and similar programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care, such as family and friends. We are not required to agree to your request; however if we do agree, we are bound by our agreement except when otherwise required by law in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy records. You may submit your request in writing to: Jaiwant Rangi, MD, FACE/ Capitol Endocrinology Inc./ 3106 Ponte Morino Drive Palmer Professional Center/ Suite C Cameron Park/ CA 95682. Or via fax: (530)676.7850.
4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the Information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: Jaiwant Rangi, MD, FACE/ Capitol Endocrinology Inc./ 3106 Ponte Morino Drive Palmer Professional Center/ Suite C Cameron Park/ CA 95682. Or via fax: (530)676.7850.
5. Right to copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or Secretary of department of health and human services. To file a complaint with our practice contact: Jaiwant Rangi, MD, FACE/ Capitol Endocrinology Inc./ 3106 Ponte Morino Drive Palmer Professional Center/ Suite C Cameron Park/ CA 95682. Or via fax: (530)676.7850.
7. Rights to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for use and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions regarding this notice or our health information privacy policies, please contact: Jaiwant Rangi, MD, FACE/ Capitol Endocrinology Inc./ 3106 Ponte Morino Drive Palmer Professional Center/ Suite C Cameron Park/ CA 95682. Or via fax: (530)676.7850.

I hereby acknowledge that I have been presented with a copy of Capitol Endocrinology Inc. / Jaiwant Rangi, MD, FACE Notice of Privacy Practices.

Signature: _____ Date: _____

Name of Patient: _____ Date of Birth: _____

I hereby authorize Dr. Jaiwant Rangi and/or staff to share pertinent health care information with _____ as of _____.

Patient Signature: _____

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MEDICAL HISTORY

DATE OF VISIT _____

LAST NAME _____

FIRST NAME _____

DATE OF BIRTH _____ AGE _____

REFERRING PHYSICIAN _____

OTHER PHYSICIANS _____

_____

REASON FOR VISIT _____

_____

_____

CURRENT MEDICAL PROBLEMS (Please list all your medical problems here)

1._____

2._____

3._____

4._____

5._____

6._____

7._____

LIST OF SURGERIES

1._____

2._____

3._____

4._____

LIST PREVIOUS HOSPITALIZATIONS

1._____

2._____

3._____

ALLERGIES: (Please write down the medications you are either allergic to or cannot tolerate and explain type of reaction, i.e. hives, wheezing, upset stomach, swelling etc.)

1._____

2._____

3._____

CURRENT MEDICATIONS

Name of drug	mg/dose **or** units of Insulin	No. of pills	How often

FAMILY HISTORY:

Father: Living - Age:_____
Deceased - Age at Death: _____
Cause: _____
Mother: Living - Age: _____
Deceased - Age at Death:_____
Cause: _____
Siblings: No. of ❑ Brothers_____❑ Sisters_____

Please list all medical problems in family members:

Medical problem	Relationship with the family member

SOCIAL HISTORY

Occupation: _____
Marital status: _____
Are you sexually active? ❑ No ❑ Yes
Are you pregnant? ❑ Not sure ❑ No ❑ Yes
Date of last menstrual periods: _____
Age at menopause: _____
Do you smoke? ❑ No ❑ Yes
If yes, how much? _____ # of packs/day
When did you stop smoking? _____
Do you drink alcohol? ❑ No ❑ Yes
If yes, how much and how often? _____
Exercise regularly? ❑ No ❑ Yes
If yes, what kind of exercise and how often?
_____

REVIEW OF SYSTEMS: (Please check if you are experiencing any of the following symptoms in the last 6 months)

GENERAL
- Weight gain ❑ No ❑ Yes
- Weight loss ❑ No ❑ Yes
- Fatigue ❑ No ❑ Yes
- Loss of appetite ❑ No ❑ Yes

ENDOCRINE
- Excessive thirst Weight ❑ No ❑ Yes
- Excessive urination ❑ No ❑ Yes
- Breast discharge ❑ No ❑ Yes
- Increase in size of hands and feet ❑ No ❑ Yes

ENT /THYROID
- Hoarseness of voice ❑ No ❑ Yes
- Swelling in the neck ❑ No ❑ Yes
- Difficulty in swallowing ❑ No ❑ Yes
- Difficulty in breathing ❑ No ❑ Yes

CARDIOVASCULAR AND CHEST
- Cough ❑ No ❑ Yes
- Difficulty breathing ❑ No ❑ Yes
- Chest pain ❑ No ❑ Yes
- Palpitations ❑ No ❑ Yes

GI SYSTEM
- Nausea / Vomiting ❑ No ❑ Yes
- Heartburn ❑ No ❑ Yes
- Stomach pain ❑ No ❑ Yes
- Diarrhea ❑ No ❑ Yes
- Constipation ❑ No ❑ Yes

BLOOD
- Anemia ❑ No ❑ Yes
- Bleeding tendency ❑ No ❑ Yes
- Heavy periods ❑ No ❑ Yes
- Easy bruising ❑ No ❑ Yes

NEUROLOGIC
- Burning ❑ No ❑ Yes
- Numbness ❑ No ❑ Yes
- Migraine ❑ No ❑ Yes

MUSCULOSKELETAL
- Have you lost height ❑ No ❑ Yes
- Any fractures in adult ❑ No ❑ Yes
- Muscle weakness ❑ No ❑ Yes
- Back pain ❑ No ❑ Yes

SKIN
- Hair loss ❑ No ❑ Yes
- Rash ❑ No ❑ Yes
- Acne ❑ No ❑ Yes

EYES
- Bulging eyes ❑ No ❑ Yes
- Loss of vision ❑ No ❑ Yes
- Laser treatment in past ❑ No ❑ Yes
- Double vision ❑ No ❑ Yes

PSYCHIATRIC
- Depression ❑ No ❑ Yes
- Anxiety ❑ No ❑ Yes
- Difficulty falling asleep ❑ No ❑ Yes

IF YOU HAVE **DIABETES** THEN ANSWER THE FOLLOWING:

What year was diabetes diagnosed? _____
What type of diabetes do you have? _____
Are you on Insulin injections or pump? _____
When did you start Insulin? _____
Who was your previous endocrinologist? _____
When did you last see an **eye doctor**? _____
Do you have retinopathy? ❑ No ❑ Yes
Laser treatment in the past? ❑ No ❑ Yes
When did you last see a **podiatrist**? _____
Do you have neuropathy? ❑ No ❑ Yes
Any numbness or tingling? ❑ No ❑ Yes
Did you have any foot ulcers? ❑ No ❑ Yes
Did you have any amputations? ❑ No ❑ Yes
Do you have heart disease? ❑ No ❑ Yes
Did you ever have a stroke? ❑ No ❑ Yes
Do you have any kidney problems? ❑ No ❑ Yes
Did you ever take diabetes education classes? ❑ No ❑ Yes

List other complications or challenges with diabetes:

CONSENT TO TREAT: I hereby authorize and consent to the performance of examinations, diagnostic procedures and treatments which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment and / or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

Patient's signature: _____

Date: _____