EAST END ENDOCRINE ASSOCIATES, P.C.

Alan Goldenberg, M.D., F.A.C.E.
Frank Albano, ANP-C
Anne Dwoskin, NP, CDE
Ann M. Silver, R.D., CDE

Naztor Commons
East End Endocrine Associates
189 Main rd. (Route 25)
Riverhead, NY 11901
Phone: (631) 288-7120
Fax: (631) 288-7124

From South Fork:

Sunrise Highway to Route 24 (Flanders Road).

Take Route 24 North to Route 105.

Make right onto Route 105 heading North.

At second traffic light make right onto Route 25 East.

We are approximately 50 feet on right hand side.

From Western Long Island

Take L.I.E. to exit 73 (Last exit).

Take Route 58 East, Route 58 turns into route 25.

Take Route 58/25 approximately 4 miles.

After the 14th traffic light, which is the intersection of Route 105, we are approximately 50 feet on the right hand side.

From North Fork

Take Route 25 West.

After the Aquebogue Post Office we are located on the left hand side before the Route 105 and Route 25 intersection.

East End Endocrine Associates, PC

PATIENT REGISTRATION **PLEASE PRINT CLEARLY**

Last Name:_____ **First Name:**_____ **Date of Birth**_____

Social Security#_____ **/ __Male __Female / __Single __Married __Other**_____

Street Address_____

City/State/Zip Code:_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Contact Preference (please circle) Home Cell Work **Primary Language**:_____

Ethnicity (please circle): Hispanic / Non-Hispanic / Deferred

Race (circle one): Caucasian / Asian / African American / American Indian / Deferred

Email Address (for access to our patient portal):_____

Mailing Address (If different than above):_____

If patient is a minor, Responsible party is:_____**Relationship**:_____

In case of emergency, contact:_____**Phone#**___**Relation:**_____

REFERRING/PRIMARY CARE DOCTOR'S NAME:_____
ADDRESS AND PHONE:_____

PHARMACY NAME AND PHONE:_____

*****PLEASE PRESENT INSURANCE CARDS FOR COPYING AND COMPLETE THE REQUESTED INFORMATION*****

Primary Insurance Company_____**Phone#**_____
Policy Holder's Name_____**Date of Birth**:_____
Policy #_____**Group#**_____**Relation to patient**:_____
Policy Holder's Employer:_____**Policy Holder's SS#**_____

Secondary Insurance Company_____**Phone#**_____
Policy Holder's Name:_____**Date of Birth**:_____
Policy#_____**Group#**_____**Relation to patient**:_____
Policy Holder's Employer:_____**Policy Holder's SS#**_____

**I hereby authorize the payment of medical benefits to East End Endocrine Associates, PC for services rendered.
**In consideration of services rendered by East End Endocrine Associates, PC to the undersigned patient, the undersigned promise to pay East End Endocrine Associates,PC any charges that the insurance company does not cover due in copayments, coinsurance, referral, deductible and non-covered services.
**I hereby authorize East End Endocrine Associates, PC to release any medical information necessary to complete and process my insurance claims.

**_____ _____
Patient's or Insured Signature (If minor, responsible party) Date

EAST END ENDOCRINE ASSOCIATES,PC - MEDICAL HISTORY FORM

PATIENT NAME:_____DATE OF BIRTH:_____

DRUG ALLERGIES: _____REACTION:_____
_____REACTION:_____
_____REACTION:_____

PLEASE LIST ANY HOSPITALIZATIONS/SURGERIES (INDICATE DATES AND REASONS)

_____
_____
_____

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:			
__ABDOMINAL PAIN-CHRONIC	__DIZZINESS/FAINTING	__PSORIASIS/ECZEMA	
__ALLERGIES/HAYFEVER	__FOOT PAIN __COLD/NUMB	__RASH/ HIVES	
__ALZHEIMERS DISEASE	__GALL BLADDER	__SEXUAL/MENSTRUAL DYSFUNCTION	
__ANEMIA	__GERD	__SINUS TROUBLE	
__ANGINA	__GLAUCOMA	__STROKE	
__ANKLE SWELLING	__GOUT	__SWALLOWING DIFFICULTY	
__ANXIETY	__HAIR LOSS	__SORE THROATS, FREQUENT	
__APPETITE LOSS	__HEADACHES/MIGRAINES	__THYROID DISEASE	
__ARTHRITIS/RHEUMATISM	__HEART ATTACK	__TREMORS	
__ASTHMA/WHEEZING	__HEART DISEASE	__ULCERS	
__ATRIAL FIBRILLATION	__HEART MURMUR	__VARICOSE VEINS/PHLEBITIS	**FEMALES ONLY PLEASE COMPLETE:**
__BLADDER PROBLEMS	__HEMORRHOIDS	__VISION- FAILING	PREGNANT Y N
__BLOOD CLOTS	__HERNIA	__WEIGHT LOSS-RECENT	PLANNING PREGNANCY Y N
__BOWEL HABIT CHANGES	__HIGH BLOOD PRESSURE		MENSTRUAL FLOW:
__BRONCHITIS/CHRONIC COUGH	__HIGH CHOLESTEROL	__OTHER: PLEASE SPECIFY_____	__REGULAR __IRREGULAR __PAIN/CRAMPS
__CANCER _____	__INDIGESTION/HEARTBURN	_____	____DAYS OF FLOW ___LENGTH OF CYCLE
__CHEST PAIN	__KIDNEY PROBLEMS	_____	FIRST DATE OF LAST PERIOD:_____
__CHRONIC FATIGUE	__LEG PAIN, FREQUENT	_____	
__CROHN'S/COLITIS	__LIVER DISEASE		
__CONVULSIONS/SEIZURES	__MEMORY LOSS		NUMBER OF PREGNANCIES:_____
__COPD	__MENTAL ILLNESS		LIVE BIRTHS____MISCARRIAGES____
__DEPRESSION	__NAUSEA/VOMITING		ABORTIONS____
__DIABETES	__OSTEOPOROSIS		BIRTH CONTROL METHOD_____
__DIARRHEA __CONSTIPATION	__PNEUMONIA		__FLUSHING/MENOPAUSE
__DIVERTICULOSIS	__PROSTATE DISEASE		LAST PAP_____ LAST MAMMO_____
FAMILY HISTORY: PLEASE CHECK ALL THAT APPLY		**HABITS:**	
__ALCOHOLISM	__MENTAL ILLNESS	ALCOHOL: TYPE_____AMOUNT_____	
__ANEMIA	__MIGRAINES	COFFEE: _____CUPS DAILY/ OTHER CAFFEINE_____	
__ARTHRITIS	__OSTEOPOROSIS	DIET: SALT INTAKE_____FAT INTAKE_____	
__ASTHMA	__STROKE	EXERCISE ROUTINE:_____	
__BLEEDING DISORDER	__THYROID DISEASE	_____	
__CANCER _____		SLEEP:	
__DEPRESSION	OTHER: (SPECIFY)_____	DIFFICULTY FALLING ASLEEP Y N	
__DIABETES	_____	CONTINUITY DISTURBANCES Y N	
__EPILEPSY/CONVULSIONS	_____	EARLY MORNING AWAKING Y N	
__GLAUCOMA	_____	DAYTIME DROWSINESS Y N	
__HAIR LOSS		OTHER:_____	
__HEART DISEASE			
__HIGH BLOOD PRESSURE		SMOKING CIGARETTES Y N PACKS PER DAY_____	
__HIGH CHOLESTEROL		HOW LONG_____ INTERESTED IN STOPPING? Y N	
__KIDNEY DISEASE			

CURRENT MEDICATIONS: (NAME/STRENGTH AND FREQUENCY)

_____
_____
_____
_____
_____
_____

East End Endocrine Associates, PC

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

I _____, acknowledge that I have read and understand, East End Endocrine Associate's Notice of Privacy Practices. This notice describes how East End Endocrine Associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

Signature of Patient or Authorized Representative Date

ACCESS TO MEDICAL RECORDS

The person/persons listed below may have access to my medical records.

_____ _____

Name Relation to Patient

_____ _____

Name Relation to Patient

I give permission for East End Endocrine Associates to leave a message on my answering machine or voice mail regarding my medical results.

_____ _____

Signature Date

_____ _____

Print Name Phone Number

EAST END ENDOCRINE ASSOCIATES OFFICE POLICIES

- 24 HOUR NOTICE IS REQUIRES WHEN CANCELLING APPOINTMENTS. IF WE DO NOT RECEIVE PROPER NOTICE, WE RESERVE THE RIGHT TO CHARGE THE PATIENT A $25.00 FEE FOR LOST TIME.
- WE REQUIRE YOU TO ARRIVE ON TIME FOR YOUR APPOINTMENT, BUT WE UNDERSTAND THAT SOME CIRCUMSTANCES MAY MAKE THIS IMPOSSIBLE, THEREFORE WE UPHOLD A STRICT 15 MINUTE LATE POLICY. WE RESERVE THE RIGHT TO RESCHEDULE YOUR APPOINTMENT IF YOU ARE MORE THAN 15 MINUTES LATE.
- IF A REFERRAL IS REQUIRED BY YOUR INSURANCE COMPANY, IT IS YOUR RESPONSIBILITY TO OBTAIN ONE FROM YOUR PRIMARY CARE DOCTOR. IF YOU DO NOT HAVE A REFERRAL YOU WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE.
- ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS AND CREDIT CARDS FOR YOUR CONVENIENCE.
- PATIENT'S ARE EXPECTED TO MAKE FOLLOW UP APPOINTMENTS TO REVIEW RESULTS. RESULTS WILL NOT BE GIVEN OVER THE PHONE. EXCEPTIONS WILL ONLY BE MADE IN CERTAIN CASES OF EMERGENCIES.

BY SIGNING BELOW, I AGREE TO AND UNDERSTAND THE ABOVE STATED OFFICE POLICIES OF EAST END ENDOCRINE ASSOCIATES.

_____ _____

SIGNATURE DATE

DUE TO SOME RECENT CHANGES AND THE AFFORDABLE CARE ACT, WE ARE AUTHORIZED TO HAVE A CREDIT CARD ON FILE.

TYPE OF CARD (MASTER/VISA/DISCOVER) CARD#_____

EXPIRATION DATE: ___/____ NAME ON CARD_____CCV#_____ZIP CODE_____