PATUXENT ENDOCRINOLOGY ASSOCIATES, LLC.
205 Steeple Chase Drive, Suite 307
Prince Frederick, MD 20678
Phone 443-432-3020; Fax 443-486-7178
Email: patuxentendo@myupdox.com

Full Name:____**Social Security #**_________________
Date of Birth:_____________**Race:**______________**Preferred Language:**____________________
Mailing Address:____
City:_______________________________________**State:**_____________**ZIP:**_______________
Phone (Home):__________________ **(Work)**__________________ **(Other)**__________________
Marital Status:___________________**Email Address:**_______________________________
Emergency Contact Name:__________________________**Relationship to you:**________
Emergency Contact Phone :_____________________**Alt Phone :**___________________________
Primary Physician:___________________________**Referring Physician:**___________________
Pharmacy:____________________________**Pharmacy Location:**_________________________

Insurance & Billing Information

Billing Name (if other than patient)___________________**Relationship:**_____________
Billing Address:____ **Phone #:**_________________

Payment Required at Time of Service – Unless Prior Arrangements Have Been Made

1. Insurance Company____________________________________ **Phone#:**_________________
Name of Insured:_____________________ **Relationship To Patient:**______________________
Member DOB:______________ **Member ID #:**________________ **Group #:**_________________

2. Insurance Company____________________________________ **Phone#:**_________________
Name of Insured:_____________________ **Relationship To Patient:**______________________
Member DOB:______________ **Member ID #:**________________ **Group #:**_________________

3. Insurance Company____________________________________ **Phone#:**_________________
Name of Insured:_____________________ **Relationship To Patient:**______________________
Member DOB:______________ **Member ID #:**________________ **Group #:**_________________

I ________________________________,certify that the information given by me is correct.

SIGN IN SPACE BELOW	
Patient/Guardian Name (printed):	
Patient Signature:	
Date signed:	

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INSURANCE AUTHORIZATION

I____, authorize direct payment of medical benefits to **Patuxent Endocrinology Associates**, for services rendered at the practice by Dr Reena Thomas, MD. I understand that I am financially **responsible for any balance not covered by my insurance.**

AUTHORIZATION TO RELEASE INFORMATION

I ____, authorize **Patuxent Endocrinology Associates**, to release any medical or incidental information needed for the insurance claim(s) to the insurance payor or other secondary insurance, as listed in my file.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Patuxent Endocrinology Associates, LLC.

MEDICARE/MEDICAID

I _________________________________, certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

NOTICE OF PRIVACY POLICY

I have received a copy of the Notice of *Privacy Practices*, and I have reviewed the below mentioned "new patient checklist" information.

SIGN IN SPACE BELOW	
Patient/Guardian Name (printed):	
Patient Signature:	
Date signed:	

NEW PATIENT CHECKLIST

REFERRAL – Please obtain a referral from your primary care physician. Check with your insurance to verify your benefits coverage. Request referrals to be faxed to 443-486-7178.

- ☐ **Medical Records** – Please call your primary care doctor and request them to fax a copy of your medical records to us.
- ☐ **Insurance card**- Please bring your current insurance card.
- ☐ **Medications**- Please bring ALL of your current medication bottles to your visit and/or a complete updated list.
- ☐ **Patients <u>with Diabetes mellitus</u>**- Please bring your blood sugar meter and blood sugar log. Please check your blood sugar 4 times a day (before each meal and bedtime) and bring in a log of the week prior to your visit.
- ☐ **Cancellation and Missed Appointments** – If you are not able to keep your appointments, please call us **<u>at least 24 hours before your appointment</u>** so that we can schedule other patients into your reserved time slot.
- ☐ **Cancellation of 24 hours is required for the cancellation of all appointments to avoid charges.**
- ☐ **Please note that the office is under video and audio surveillance for safety and workplace improvements.**