Duc H. Do, M.D., F.A.C.E.

355 Placentia Ave, Suite 207A Newport Beach, CA 92663-3302
Phone (949)574-4114 Fax (949)574-4144 E-mail DucDoEndo1@gmail.com

Patient Information:

Today's Date:õ õ õ õ õ õ õ õ õ õ õ õ ..

Sex: M F

Name:____
Last First Middle

MaritalStatus: S M D W

Date of Birth:_____/_____/_______**Age:**__________

Address:______________________________**City:**________________**State:**_____**Zip:**__________

Cell Phone: ( )_______________**Other Phone:** ( )______________**E-mail:** ________________
(for nonclinical matters)

S.S.#: ________________ **ANY ALLERGIES:**________________________(or NONE)

Employer:______________________**Work Phone:**( )__________**Occupation:**________________

Insurance Information: **We do NOT accept CalOptima, Covered CA, Medi-Medi, or any HMO other than Greater Newport Physicians**

Primary Insurance:________________**Primary Subscriber Name:**______________**Relationship to Pt:** __________

Primary Subscriber (if other than self) DOB: ____/____/____ **S.S.#:**__________**Insurance Policy ID#:**______________

Secondary Insurance:______________**Primary Subscriber Name:**__________ **Relationship to Pt:** __________

Primary Subscriber (if other than self) DOB: ____/____/____ **S.S.#:**__________**Insurance Policy ID#:**______________

Spouse's Information:

Name:____**Date of Birth:**______/______/______

Employer:______________________**Work Phone:** ( )______________

Address:______________________________**City:**________________**State:**_____**Zip:**__________

Referral Information:

Referred by:

Physician:______________________________**Other:**______________________

Emergency Contact: (someone not living with you)

Name of person to contact: ______________________________**Relationship:**______________

Address:______________________**City:**________________**State:** _______**Zip:** __________

Home Phone: ( ) ____________________**Work Phone:** ( )____________________

ADVANCE DIRECTIVES: If you need information or inquiring about advance directives (Durable Power of Attorney for Health Care, Natural Death Act Declaration or living will) please call the member services department of your health plan.

ASSIGNMENT OF BENEFITS:

I hereby assign my insurance benefits to be made directly to Dr. Do and any assisting physicians, for services rendered.

Date:______________**Signature:** ______________________________

INSURANCE ELIGIBILITY AND FINANCIAL AGREEMENT:

I hereby attest that I am eligible member of______________________________insurance company and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company.

Date:______________**Signature**______________________________

RELEASE OF MEDICAL RECORDS/AUTHORITY TO LEAVE MESSAGES ON ANSWERING MACHINE OR ANOTHER PERSON ANSWERING THE PHONE. (we will not leave results on machine without patient's permission) I hereby authorize Dr. Do to release all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original.

Date:______________**Signature:**______________________________

ACCOUNTSMANAGEMENT:

Co-payment is due at the time service is rendered. All charges are the direct responsibility of the patient. We cannot render services on the assumption that our charges will be paid by the Insurance Company. Insurance is an agreement between you and your insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs, $25 bounced check fee, and any related fees to your bill. I hereby acknowledge that I have read, understood, and agree to hereby give consent for treatment.

Date:______________**Signature:**______________________________

Duc H. Do, M.D., F.A.C.E
355Placentia Ave., Suite #207A Newport Beach, CA 92663-3302
DucDoEndo1@gmail.com

Name:____ Date of Birth:______/______/______
Last First MI

E-mail address: (for non-urgent, non-clinical matters only) ______________________________

Referring physician:____________________ **Ref. physician FAX #:** (.........) ....-.....................

Physicians involved in your care & reasons for their involvement:

1.______________________________ **4.**______________________________

2.______________________________ **5.**______________________________

3.______________________________ **6.**______________________________

Reasons for consultation with Dr. Duc Do:

____

____

Preferred Pharmacy Name & Phone #: ______________________ **P#: (   )   -**

PAST MEDICAL HISTORY

Have you had any of the following? If yes, give details:

NEUROLOGY	**N**	**Y**	***ENDOCRINOLOGY***	**No**	**Y**	***RESPIRATORY***	**No**	**Y**
Seizures			Diabetes? If yes, since what year:			New cough		
Poor concentration						Wheezing		
Memory loss			Insulin use for diabetes			Coughing up blood		
Vertigo			Diabetes Education			Asthma		
Strokes			Any dietary restriction			***HEMATOL/ONCOL***	**No**	**Y**
Visual changes			Low carbohydrate diet			Anemia		
Easy irritability			Diabetes in pregnancy			Leukemia		
New headache			Goiter			Bleeding disorders		
Unexplained fatigue			Thyroid nodule			Cancer of organs		
Afternoon somnolence (sleepiness)			Underactive thyroid			***MUSCULO-SKELETAL***	**No**	**Y**
Non-refreshing sleep			Overactive thyroid			Hand Shakiness		
EAR NOSE THROAT,	**N**	**Y**	Any other thyroid disorder			Rheumatoid arthritis		
RADIATION TREATMENT			Surgery on thyroid			Osteoarthritis		
Pain in the front neck			Cold intolerance			Lupus		
Neck swelling			Heat intolerance			Any muscle disorders		
Difficulty in swallowing			Difficulty losing weight			Osteoporosis		
Hoarseness of voice			Unintentional weight loss			Broken bones not from		
Loud snoring			Calcium disorder			***SKIN/HAIR***	**N**	**Y**
CARDIOVASCULAR	**N**	**Y**	Pituitary gland disorders			Dry skin		
Heart irregularity			Diabetes insipidus			Skin color changes		
Heart palpitation			Excessive hunger			Brittle nails		
Heart attack			Excessive sweating			Abnormal hair loss		
Heart failure			Easy bruising			Abnormal hair growth		
Heart surgery			Excessive thirst			Acne		
Angina			Excessive urination			***GENITO-URINARY***	**N**	**Y**
Heart valve problem			Recent breast size changes			Kidney stones		
Shortness of breath			Unusual discharge from			Kidney infection		
GASTROINTESTINAL	**N**	**Y**	Menstrual changes ϒ			Blood in urine		
Stomach/duodenal ulcers			Hot flashes ϒ			Disease of uterus (F) ϒ		
Bleeding from stomach			Abortions ϒ			Difficulty w/erection		
Gallstones			Difficulty conceiving			Absence of erection at		
Nausea /Vomiting			Menstrual irregularity ϒ			Prostate enlargement		
Frequent bowel movements			Lack of desire for sex ϒ			Prostate cancer		
Constipation			Disease of ovaries (F) ϒ			Disease of the testes ϒ		

Duc H. Do, M.D., F.A.C.E
355Placentia Ave., Suite #207A Newport Beach, CA 92663-3302
DucDoEndo1@gmail.com

What is your age of onset of periods?		ANY MAJOR PROCEDURES/HOSPITALIZATIONS?	What year?
What is interval between menstrual periods?			
Age of menopause, if applicable?			

List any other past medical history:

____

FAMILY HISTORY:

List family members who have had the following:	Diabetes, type 1 or 2?	Thyroid disease	Heart illness	High blood pressure	Cancer	Any hereditary disease

Relationship	Age	Any Illnesses?	Alive/Dead		Cause of death
Father					
Mother					
Brother					
Brother					
Sister					
Sister					
Son					
Daughter					

SOCIAL HISTORY:

- Do you exercise regularly? If yes what do you do?____
- Have you followed a diet program?____
- Have you used tobacco? If yes, when & how much a day?_________________________________
- Have you used alcohol? If yes, when & how much a day?_________________________________
- Have you used any illicit drugs? If yes, please list____________________________________

ALLERGY: **List** all allergies to any agent or medication **(or indicate <u>NONE</u>)**:____________________
Also indicate what kind of reactions?: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

LIST ALL MEDICATIONS/VITAMINS YOU ARE TAKING (Please <u>list all</u> medications taken, **<u>including prescription drugs, insulin, vitamins, dietary supplements, over-the-counter products, health food products, etc</u>.):**

NAME	STRENGTH	HOW OFTEN	DATE STARTED
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			

DUC H. DO, M.D., F.A.C.E.
355 Placentia Ave., Suite 207A
Newport Beach, CA 92663-3302
Phone (949) 574-4114

PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practice (õNoticeö) provides information about:

1.) the privacy rights of our patients; and
2.) how we may use and disclose protected health information (õPHIö) about our patients.

Federal regulation requires that we give out patient or their authorized representatives (õYouö) the opportunity to review our Notice before signing this acknowledgment. A two-page summary of our Notice is displaced in our office and in the hospital we serve. A copy of our Notice will be made available to you upon request.

If you have any questions about your rights or our privacy practice please send a letter to:

Privacy Officer
Duc H. Do, M.D.
355 Placentia Ave. Suite #207A
Newport Beach, CA 92663-3302

We will respond to you within five (5) business days.

By signing this form, you acknowledge only that we have provided you with immediate access to our Notice of Privacy Practices.

____________________________________ ________________
Signature of Patient or Authorized Representative Date

_____________________________________ ____________________________________
Print Name of Patient Print Name of Representative

DIPLOMATE, AMERICAN
BOARD OF ENDOCRINOLOGY
AND METABOLISM

DUC H. DO, M.D., F.A.C.E.

355 PLACENTIA AVE., SUITE 207A
NEWPORT BEACH, CA 92663-3302
P#: (949) 574-4114 | F#: (949)574-4144

MEMBER, AMERICAN
ASSOCIATION OF CLINICAL
ENDOCRINOLOGISTS

48 Hour Cancellation & "No Show" Fee Policy

Recognizing that everyone's time is valuable and the appointment time is limited, we ask that you provide a 48 hour notice if you are unable to keep your appointment. This 48 hour notice, excluding holidays and weekends, must be made during open office hours between 8:00 am to 4:00 pm with a live agent. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, the office of Dr. Do reserves the right to charge a fee of $30.00 for each missed (No Show) appointment, which is, absent for a compelling reason and is not cancelled within a 48 hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your appointment. Multiple "No Shows" in any 12 month period will result in termination from our practice.

Thank you for your anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

____

Printed, Last Name, First   Date

____

Signature

MEDICAL RECORD RELEASE
Incoming New Patient

Patient Information: (please print)

Patient Name: ___________________________________ Date of Birth: ____________

Address: ____

Telephone #: ______________________________

I authorize the named health care provider:

Dr: ____

Address: ____

Telephone #: ______________________ Fax #: _______________________

to release the information or records specified to:

Dr. Duc Do, M.D.

Address: 355 Placentia Ave, Suite 207A Newport Beach, CA 92663-3302

Telephone #: (949) 574-4114 Fax #: (949) 574-4144

Information to be Released (check all that apply)

□▪ 3 Most Recent Lab Reports

□▪ Last 2 years of Imaging Reports

□▪ Last 2 years of Operative Reports

□▪ Last 2 years of Pathology Reports

Authorization (authorization remains valid for 90 days from date of signature)

Patient Signature: _ Date: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _