



A. Rodman Barber, MD, FACE  
Board Certified: Endocrinology

Venkatarama S. Donepudi, MD, FACE  
Board Certified: Endocrinology

Ebele C. Chira, MD  
Board Certified: Endocrinology

311 Ninth Avenue Drive NE  
Hickory, North Carolina 28601  
Phone: (828) 322-7338 Fax: (828) 304-6319

Enclosed are forms for you to complete prior to your appointment. Please bring these completed forms with you at your first visit. One hour of the doctor's time is scheduled for you. **You will need to call our office and confirm this appointment 3 business days prior to your appointment date or your appointment will be cancelled.**

We will file charges to your insurance company. Please bring your insurance information with you. If your insurance plan requires authorization from your primary care physician (to see a specialist) please call your primary care physician at least 2 weeks prior to your appointment to obtain this. Without prior authorization your insurance company will not pay for this visit and you will be responsible for payment on the day of your visit. As a courtesy, we will file to your secondary insurance but if payment is not received 30 days after we file to your secondary insurance, we will bill the amount owed to you.

If you are being seen for your thyroid, we will need results of thyroid ultrasounds or thyroid biopsies done in the recent past to save you from having to repeat these studies. Please obtain these or ask your physician to send them to us in advance of your visit. (If you had a scan **brings the actual film**, not just the report.)

If you are diabetic, please bring your glucometer and blood sugar logbook to every visit.

We ask that you not wear perfumes, scented lotions or aftershave cologne to your appointments.

Thank you for choosing Piedmont Endocrinology.



### **Directions to Piedmont Endocrinology**

311 Ninth Avenue Drive NE  
Hickory, NC 28601-3829

#### **From Interstate 40:**

Taking Exit 125, turn **North (Left if coming from Hildebran/Morganton area, Right if coming from Conover/Statesville area)** onto **Lenoir-Rhyne Boulevard SE**. Follow Lenoir-Rhyne Boulevard until you reach the intersection of Lenoir-Rhyne Boulevard and Tate Boulevard. You will see a "Hwy 127" sign and "Welcome to Hickory" sign. At this intersection take a **Left** onto **1<sup>st</sup> Avenue SE**, and then take a **Right** at the next traffic light onto Hwy 127 North (2<sup>nd</sup> St NE). You will go through five traffic lights. You will see Kingston Residence, Allergy & Asthma Associates, and Shook & Tarlton Building on the right. Turn **right at Salsarita's onto 9<sup>th</sup> Ave Dr NE**. Our building is the second on your left. **Go to the second drive for Patient Parking.**

#### **From Hwy 321 South:**

Coming **South** on **HWY 321** you will turn **left at the stoplight intersection where you see Arby's and Nissan of Hickory** onto **Old Lenoir Road**. There will be a shopping center to the right with Lowe's Grocery Store. Once you pass the shopping center, look for Hickory Animal Hospital. Take a **left onto 12<sup>th</sup> Avenue NW directly in front of the animal hospital**. Follow 12<sup>th</sup> Avenue NW until you reach the end at the stoplight. There you will take a **left onto 6<sup>th</sup> Street NW**. At the **third traffic light you will take a right onto 2<sup>nd</sup> Street NE (Hwy 127 North.)** Watch for **Pure Service Station, Panera Bread and Salsarita's on your left, slowing to turn at Salsarita's onto 9<sup>th</sup> Ave Dr NE**. Our building is the second on your left. **Go to the second drive for Patient Parking.**

#### **From Hwy 321 North:**

Stay on 321 until you get to Hwy 127. Exit here and turn right going north. Go straight over I-40 and into downtown. Continue about 4 miles. You will pass Fire Station on left and Frye Regional Medical Center also on Left (one block over). **You will see Kingston Residence, Allergy & Asthma Associates and Shook & Tarlton on your right. Turn right at Salsarita's onto 9<sup>th</sup> Ave Dr NE**. Our building is the second on your left. **Go to the second drive for Patient Parking.**

#### **From Hwy 127 North:**

Follow Hwy 127 North through the Bethlehem community, crossing Lake Hickory. Continue into Hickory as the street (Hwy 127) becomes 2<sup>nd</sup> Street NE. Watch for Pure Oil Station, Panera Bread and Salsarita's, **slowing to turn at Salsarita's onto 9<sup>th</sup> Ave Dr NE**. Our building is the second on your left. **Go to the second drive for Patient Parking.**

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**PATIENT INFORMATION**

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Patient Name: \_\_\_\_\_  
Last First Middle Maiden  
Address: \_\_\_\_\_  
Zip Code: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Sex: Female Male  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Marital Status: Married Single Widowed  
Patient's Employer: \_\_\_\_\_ Employment: Full Part Self Empl. Unempl. Retired  
Referred By Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
In case of an emergency please contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
May we leave messages related to your care with above or on answering machine? Yes No

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**RESPONSIBLE (OR INSURED) PARTY INFORMATION**

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Responsible Party Name: \_\_\_\_\_  
Last First Middle Maiden  
Patient Relationship to the Responsible Party: Self Spouse Child Other  
Address (if different from above): \_\_\_\_\_  
Zip Code: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Sex: Female Male  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Responsible Party's Employer: \_\_\_\_\_ Employment: Full Part Self Empl. Unempl. Retired

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**INSURANCE INFORMATION**

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**Leave this section blank if you bring your card(s) with you.**

Primary Insurance Company: \_\_\_\_\_ Eff. Date: \_\_\_\_\_ Phone: \_\_\_\_\_  
Claims Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Contract or ID #: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_  
Subscriber's Date of Birth: \_\_\_\_\_ Patient Relationship to Subscriber: Self Spouse Child Other  
Group Name: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Co-Payment Amount: \$ \_\_\_\_\_ or Deductible \$ \_\_\_\_\_ Has Deductible Been Met This Year? \_\_\_\_\_

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Secondary Insurance Company: \_\_\_\_\_ Eff. Date: \_\_\_\_\_ Phone: \_\_\_\_\_  
Claims Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Contract or ID #: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_  
Subscriber's Date of Birth: \_\_\_\_\_ Patient Relationship to Subscriber: Self Spouse Child Other  
Group Name: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Co-Payment Amount: \$ \_\_\_\_\_ or Deductible \$ \_\_\_\_\_ Has Deductible Been Met This Year? \_\_\_\_\_

**As a courtesy, we will bill your secondary insurance. If payment not received 30 days after filing, the balance owed will be your responsibility.**



## PIEDMONT ENDOCRINOLOGY CONSULTATION

NAME \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Initial

### FAMILY HEALTH HISTORY:

(Such as heart disease, High blood pressure, stroke, cancer, diabetes, thyroid disease, mental illness)

Relationship to you	Age if still living	If not alive, age person died	Diseases person has or had and cause of death if deceased
Mother			
Father			
Brother			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			
Sister			

### PERSONAL AND SOCIAL HISTORY:

Where were you born? \_\_\_\_\_ With whom do you live now? \_\_\_\_\_

Children: None \_\_\_\_\_ ; or (give sex and age in years) \_\_\_\_\_

Present weight: \_\_\_\_\_ pounds The most you ever weighed (not pregnant): \_\_\_\_\_ pounds

Has your weight changed in the past year? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes: Gained \_\_\_\_\_ pounds Lost \_\_\_\_\_ pounds

Reason for weight gain or loss: \_\_\_\_\_ ; or N/A \_\_\_\_\_

Your height: \_\_\_\_\_ inches. Have you lost height? Yes \_\_\_\_\_ No \_\_\_\_\_ If you have lost height, how much? \_\_\_\_\_ inches

Average number of hours you sleep each day \_\_\_\_\_ hours

Do you have trouble sleeping? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what is the problem? \_\_\_\_\_

Do you get exercise or do heavy work each week? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, you do \_\_\_\_\_ hours each week

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, amount and type of alcohol used each week: \_\_\_\_\_

Have you used "recreational" drugs (marijuana, heroin, crack). Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what? \_\_\_\_\_

Do you have problems with your sexual function? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what is the problem? \_\_\_\_\_

Have you used tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what? \_\_\_\_\_ How much? \_\_\_\_\_

For how long? \_\_\_\_\_ (years). If you have quit, what year did you quit? \_\_\_\_\_

Highest education level you completed: \_\_\_\_\_ GED \_\_\_\_\_ High school \_\_\_\_\_ College \_\_\_\_\_ Graduate school

Are you are on a restricted diet? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what do you restrict? \_\_\_\_\_

Do you drink caffeine beverages (coffee, cola, tea)? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many ounces a day? \_\_\_\_\_ ounces

What are your hobbies, recreational activities? \_\_\_\_\_

What is your current job? \_\_\_\_\_ Your past jobs: \_\_\_\_\_

If you served in the military service, give branch \_\_\_\_\_ and years \_\_\_\_\_

# PIEDMONT ENDOCRINOLOGY CONSULTATION

NAME \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Initial

## PAST MEDICAL HISTORY:

How healthy are you now (check one):  GOOD  FAIR  POOR

List drugs you are allergic to: \_\_\_\_\_

Last year you had: Tetanus booster  Pneumo Vaccine  Flu Vaccine  Hep B Vaccine  None

Check if you had:  Rheumatic fever  Malaria  Other serious infections: \_\_\_\_\_ None

## PAST HOSPITAL ADMISSIONS:

Year admitted	Cause of illness		Year admitted	Cause of illness

## REVIEW OF THE SYSTEMS

### EYES, EARS, NOSE, THROAT (CHECK YES OR NO FOR ALL LISTED)

- Loss of hearing .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Lightheadedness .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Hoarseness .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Loss of sense of smell .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Sinus trouble .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Constant or frequent nasal stuffiness .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Loss of ability to taste food .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Repeated nose bleeding .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Chronic dryness of the mouth .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Wear glasses or contacts .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Blurred vision and glasses don't help .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Double vision .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Glaucoma .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Sense of something in the eyes all the time .....Yes \_\_\_\_\_ No \_\_\_\_\_

Year last saw dentist: \_\_\_\_\_ Name of dentist: Dr. \_\_\_\_\_

Year last saw eye doctor: \_\_\_\_\_ Name of eye doctor: Dr. \_\_\_\_\_

### LUNGS and HEART (CHECK YES OR NO FOR ALL LISTED)

- Short of breath even with little effort .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Heart murmur .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Wake up at night very short of breath .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Exposed to tuberculosis .....Yes \_\_\_\_\_ No \_\_\_\_\_
- If yes, Year \_\_\_\_\_ Treatment given? \_\_\_\_\_
- Positive skin test for tuberculosis .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Pain, discomfort, or tightness in chest .....Yes \_\_\_\_\_ No \_\_\_\_\_
- High blood pressure .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Pain or lumps in breasts .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Breast biopsies .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Persistent cough .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Cough up blood .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Cough up phlegm or sputum .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Asthma .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Palpitations or racing of the pulse .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Repeated episodes of bronchitis .....Yes \_\_\_\_\_ No \_\_\_\_\_
- Drenching night sweats .....Yes \_\_\_\_\_ No \_\_\_\_\_

# PIEDMONT ENDOCRINOLOGY CONSULTATION

NAME \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Initial

## LUNGS AND HEART (CHECK YES OR NO FOR ALL LISTED)

Swelling of the legs or ankles ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Severe pain in the calves while walking or running ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Had an electrocardiogram (EKG) ..... Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, year of last one \_\_\_\_\_  
Had a chest x-ray ..... Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, year of last one \_\_\_\_\_  
Had a mammogram ..... Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, year of last one \_\_\_\_\_  
Had an exercise or stress test ..... Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, year done \_\_\_\_\_

## STOMACH, INTESTINES & LIVER (CHECK YES OR NO FOR ALL LISTED)

Severe problem with stomach gas, bloating, or passing gas..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Heartburn ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Use antacids regularly ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Frequent nausea ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Have frequent or unexplained vomiting ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Vomit blood ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Stomach or abdominal pain ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Bloody bowel movements ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Loose bowels most of the time ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Constipation most of the time ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Hemorrhoids ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Rectal pain or bleeding ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Colon polyps ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Ulcers ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Had hepatitis or yellow jaundice ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Had an Xray of the stomach ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Had an endoscopy (a lighted tube exam) of stomach ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Had a CAT scan or MRI of the abdomen ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Had an X-ray or ultrasound of gallbladder ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Had a sigmoidoscopy or colonoscopy of the colon ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Had a barium enema Xray of the colon ..... Yes \_\_\_\_\_ No \_\_\_\_\_

## KIDNEYS & BLADDER (CHECK YES OR NO FOR ALL LISTED)

Had a kidney ultrasound or IVP ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Get up at night just to urinate. .... Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many times a night? \_\_\_\_\_  
Unable to control bladder and have accidents ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Weaker and slower urine stream ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Blood in urine ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Kidney stone ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Urinary, kidney or bladder infections ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Venereal disease ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Burning or pain during urination ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Protein in urine ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Constant feeling of a need to urinate ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Trouble or hesitancy in getting urine flow going ..... Yes \_\_\_\_\_ No \_\_\_\_\_

## MALE ORGANS - MEN ONLY (COMPLETE IF THIS APPLIES)

Prostate trouble ..... Yes _____ No _____
Burning or discharge from penis ..... Yes _____ No _____
Swelling, pain, tenderness, or a lump on testicles ..... Yes _____ No _____
Trouble with erections ..... Yes _____ No _____
Had a vasectomy ..... Yes _____ No _____

# PIEDMONT ENDOCRINOLOGY CONSULTATION

NAME \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Initial

## FEMALE ORGANS - WOMEN ONLY (COMPLETE IF THIS APPLIES)

Have you been pregnant ..... Yes \_\_\_\_\_ No \_\_\_\_\_

If yes:

Number of times you have been pregnant \_\_\_\_\_

Number of miscarriages or abortions you have had \_\_\_\_\_

Number of children you delivered \_\_\_\_\_

Number of living children you have \_\_\_\_\_

Complications of pregnancy. Describe: \_\_\_\_\_

Age periods began: \_\_\_\_\_ years

Had tubes tied ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Had a hysterectomy ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Had ovaries removed ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Date last period began \_\_\_\_/\_\_\_\_/\_\_\_\_

Periods are about every \_\_\_\_\_ weeks and last about \_\_\_\_\_ days

Periods are abnormally heavy ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Bleeding between periods ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Had the menopause but am bleeding now ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Severe cramps with period and use medication for these ..... Yes \_\_\_\_\_ No \_\_\_\_\_ Medication used: \_\_\_\_\_

Repeated episodes of vaginitis ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Pain with intercourse ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Contraceptive use. Use: \_\_\_\_\_

Year of last PAP smear \_\_\_\_\_ Done by \_\_\_\_\_

## MUSCLES, JOINTS & SKELETON (CHECK YES OR NO FOR ALL LISTED)

Had fractures of bones ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Severe or unusual muscle cramps ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Stiff joints ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Painful muscles ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Swollen joints ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Pain or stiffness in spine ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Regular or repeated treatment for back ..... Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, treatment is by \_\_\_\_\_

## NERVOUS AND PSYCHIATRIC (CHECK YES OR NO FOR ALL LISTED)

Nervous breakdown ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Psychiatric treatment ..... Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, treated by \_\_\_\_\_

Unusual weakness of muscles ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Sick headaches ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Numbness of part of body ..... Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, which part? \_\_\_\_\_

Paralysis in or loss of use of part of body ..... Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, which part? \_\_\_\_\_

Stroke ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Pass out, fainting or loss of consciousness ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Seizures or convulsions ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Unusual shaking or trembling ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Depressed ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Easily annoyed or irritable ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Disturbed greatly by family ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Disturbed greatly by work ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Disturbed greatly by other things ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Considering suicide ..... Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, by what means? \_\_\_\_\_

Attempted suicide ..... Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, by what means? \_\_\_\_\_

Memory failing ..... Yes \_\_\_\_\_ No \_\_\_\_\_

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Last First Initial

## ENDOCRINE (CHECK YES OR NO FOR ALL LISTED)

- Big problem with heat or hot weather ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Big problem with cold or cold weather ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Excessive perspiration ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Trouble swallowing ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Goiter or enlarged thyroid gland ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Nodule on thyroid gland ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Tender thyroid or pain in the front of your neck ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Excessive appetite ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Poor appetite ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Exhaustion or fatigue most of the time ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Reduced libido or a poor sex drive ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Breast discharge ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Change in voice ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Excessive body or facial hair ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Problem with acne ..... Yes \_\_\_\_\_ No \_\_\_\_\_

## OTHER PROBLEMS (CHECK YES OR NO FOR ALL LISTED)

- Pain in feet ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Phlebitis ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Pulmonary embolus ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Bleeder ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Rash now or often ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Chronic itching ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Growth in the skin ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Had or now have cancer ..... Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, type? \_\_\_\_\_
- Radiation therapy ..... Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, for? \_\_\_\_\_
- Anemic ..... Yes \_\_\_\_\_ No \_\_\_\_\_
- Swollen lymph glands ..... Yes \_\_\_\_\_ No \_\_\_\_\_

**PATIENT: PLEASE DO NOT WRITE BELOW HERE**

Date reviewed \_\_\_\_/\_\_\_\_/\_\_\_\_ by \_\_\_\_\_

A. Rodman Barber, MD, FACE  
Venkatarama S. Donepudi, MD, FACE  
Ebele C. Chira, MD



**Authorization for Release of Medical Records**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Piedmont Endocrinology, PA, receives all of our patients on a consulting basis by physician referral only. It is our practice to send office notes, diagnostic and lab results from each visit to the referring physician and/or any other physician that you request in an effort to provide accurate and concise communication regarding your care here. By signing below, you agree and authorize the release of our office notes, diagnostic and lab results to the physician who referred you to our practice. We will not re-release any medical records we receive from other physicians.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please list any persons and their relationship you authorize Piedmont Endocrinology, PA to disclose any of your protected health information to (i.e. family members, physicians, physician offices, etc).

_____	_____
_____	_____
_____	_____

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

You may update this release at any time by filling out a new form. You may revoke this release at anytime by submitting your request in writing to Piedmont Endocrinology at the address above

**Consent for Records Release to Health Insurer(s)**

As a specialist, we are often required to release medical information to your health insurance in order for them to process claims. By signing below, you agree and authorize the release of our office notes, diagnostic and lab results that may be requested by your health insurer to your health insurer. We will not re-release any medical records we receive from other physicians.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Patient Financial Responsibility

**The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services rendered.**

- Prompt payment allows us to control costs. Outstanding accounts cost both the patient and the practice time and money; therefore, all patients will be required to establish financial arrangements for payment of their account.
- It should be noted that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your carrier, and to ensure your carrier remits payment for your account.
- All insurance co-payments are due and payable at the time of service prior to being seen. There are no exceptions.
- As a courtesy to you, we will file claims with your insurance company. Once your insurance company has processed your claim, you are responsible for any balance due. If the insurance company later provides additional payments on your claim you will receive any appropriate refund promptly.
- Once your insurance company has processed your claim, you will receive a statement for services, which is due and payable within thirty days of the statement date. If your payment is late, or if you have not made financial arrangements, we will mail you a reminder notice indicating a problem with your account. It is imperative that you contact us immediately upon receipt of such notice.
- It is your responsibility to understand your plan guidelines regarding providers and hospitals that your plan is contracted with because employers do occasionally change their insurance plans, even if they do not change insurance companies.
- For your convenience, we accept Visa, MasterCard, check, or cash in payment for services. Please do not send cash in the mail. There is a \$25 service charge for checks that are returned.
- If you are experiencing a set of financial circumstances beyond your control, please call our practice and we will be happy to make special payment arrangements.
- Failure to adhere to the above policies could result in your account being turned over to an outside collection agency. Any fees associated with this will be your responsibility.
- There is an administration fee of up to \$35 or in accordance with applicable law, payable in advance, for you to receive a copy of your medical records. This fee may be waived if your records are sent directly to another physician. This fee does not apply to records sent to your insurance company.
- It is important that we have accurate insurance information for all our patients. It is likely that you will be asked to show your current card on each visit. If you fail to provide your card, you will be required to pay that day any anticipated charges for the visit. If you are able to provide the card at a later time, we will refund any covered fees and file with your insurance company.
- In order to provide quality care, it is crucial that we have current contact information, including insurance information. If you are unable to provide this, we will not continue to provide healthcare services for you.

Piedmont Endocrinology firmly believes that a good doctor/patient relationship is based upon understanding and open communication. Our staff has been instructed to make every effort to assist you in managing your account. We hope to avoid any disagreement over payment for professional services by clearly defining our policies at the onset. If you have any questions concerning this policy or need any assistance with your account in the future, please contact us immediately.

I have read the above financial agreement and agree to abide by the terms set forth in it.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient, Parent or Guardian

Please print your name here: \_\_\_\_\_



## Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Piedmont Endocrinology has informed me of their “Notice of Privacy Practices”. I have been given the right to review their “Notice of Privacy Practices and understand Piedmont Endocrinology has the right to change their “Notice of Privacy Practices” from time to time and that I may contact Piedmont Endocrinology to obtain a current copy.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient, Parent or Guardian

## Understanding of Commitment to Care

We are dedicated to providing you with the best possible care and service, treatment. Nationally there is a shortage of Endocrinologist therefore limiting the availability of appointment time and resources to meet patient needs. This practice has established the following criteria in an effort to provide the highest level of care for our patients.

- If you are a diabetic, please bring your glucometer and blood sugar logbook to every visit.
- Patients must give **48 hours** notice if a scheduled appointment is not going to be kept.
- Patients who **cancel or no show** for appointments may be discharged from the practice. In the event a patient is discharged from the practice it will be the family’s responsibility to access care at another facility with the assistance of their primary care physician.