REGISTRATION

Last Name _____ First Name _____

MI _____ Date of Birth (M/D/Y) _____/_____/_____

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ -_____ Cell/Mobile Phone ( ) _____ -_____

Referring Doctor _____ Primary Care Doctor _____

□ Male □ Female □ Married □ Single □ Other

Emergency Contact _____ Phone ( ) _____ -_____

Employer _____ Occupation _____

□ Asian □ Black or African American □ Hispanic □ White □ Other

Pharmacy name: _____ Address or phone: _____

Email _____@_____ □ SELF PAY □ Medi-Cal

Primary Insurance:_____
Subscriber's information (if different from self):
First Name_____ MI___
Last Name_____ □ Male □ Female
DOB_____/_____/_____ Employer_____
Your Relationship: □ Spouse □ Child □ Other

Secondary Insurance: _____
Subscriber's information (if different from self):
First Name_____ MI___
Last Name_____ □ Male □ Female
DOB_____/_____/_____ Employer_____
Your Relationship: □ Spouse □ Child □ Other

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my healthcare, Dr. Jue originates and maintains paper and/or electronic records. I understand that uses of my healthcare and health information include: for treatment, payment, healthcare operations, associates and as required by law. I understand I have the right to inspect and copy my records, and the right to request amendments, restrictions, confidential communications, and accounting of certain disclosures. I have been provided with and may keep a copy of the Notice of Privacy Practices.

FINANCIAL AGREEMENT AND CANCELLATION POLICY

I agree to provide a deposit at the time of service for anticipated patient cost-share or when cost-share cannot be reasonably determined by online verification. I acknowledge that a no-show or cancellation made without a 24 hour advance notice may incur a charge. I am responsible for all copays, deductibles, and any other charges not covered by insurance. Any outstanding balance may be turned over to a collection agency after 60 days from the initial statement date. I acknowledge I am responsible for all costs associated with collection efforts of an unpaid balance.

CONSENT, ASSIGNMENT, RELEASE AND AUTHORIZATION

I consent to services provided by Dr. Jue and associates and understand that I have the right to refuse services. I authorize my insurance companies, including Medicare, to pay Dr. Jue or his billing service directly for any services provided. I am responsible for determining whether services are in-network. I authorize the release of necessary medical information to my insurance companies, including Medicare, to secure the payment of benefits. I understand that I am financially responsible for all non-covered services. If the insurance company fails to issue a prompt payment, I agree to assist Dr. Jue or his billing service to collect the payment or settle my bill personally. A copy or image of this release and authorization is as valid as the original.

Signature (Patient or Guardian) _____ Date:_____

Dyron J. Jue, MD, Endocrinology. Tel: 408-280-0755. Email: mdjuestaff@gmail.com. Address: 2101 Forest Ave, Ste 100, San Jose, CA 95128.

Welcome: New Patient Questionnaire

Last Name:_____ First Name:_____ DOB:_____/_____/_____

Reason for visit:_____ □ Diabetes □ Thyroid □ Thyroid lump □ Osteoporosis □ Testosterone

Mark all that apply:

I am a: □ never smoker □ former smoker □ current smoker

I have a family history of: □ heart attack or heart disease □ diabetes □ thyroid disorder □ thyroid cancer □ osteoporosis

Mark YES or NO if you have any of the following symptoms:

	Y	N		Y	N		Y	N
fatigue	□	□	nausea	□	□	itchiness	□	□
weight loss	□	□	urinary frequency	□	□	constipation	□	□
blurry vision	□	□	muscle ache	□	□	dry skin	□	□
increased thirst	□	□	skin flushing	□	□	hair loss	□	□
voice change	□	□	numbness	□	□	tremor	□	□
chest pain	□	□	memory difficulty	□	□	palpitations	□	□
short of breath	□	□	cold sensitivity	□	□	swallowing difficulty	□	□
diarrhea	□	□	easy bruising	□	□			

My height: _____ feet _____ inches

Any allergies to medications? □ No known allergies □ Yes

If yes, please list:_____

Current Medications: (name, strength, directions) If a list is available, please ask us to make a copy.

_____
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