Eiriny Eskander, M.D.

16311 Ventura Blvd. Suite 850 Encino, CA 91436
Tel: (818) 918-2008 Fax: (818) 483-4854

PATIENT INFORMATION SHEET

Date__/_____/_____

LAST NAME: _____FIRST NAME:_____

ADDRESS: _____

CITY: _____STATE_____ZIP CODE _____

SEX: M / F BIRTHDATE: ___/_____/_____ AGE: _____YRS.

SOCIAL SECURITY #: _____-_____-_____
(Necessary for payment purposes)

HOME PHONE: (___)_____ WORK PHONE: (__)_____

CELL PHONE: (____)_____ EMAIL: _____

CALIFORNIA RESIDENT: YES / NO PATIENT'S MAIDEN NAME _____

MARITAL STATUS: _____ SPOUSE NAME: _____

MAILING ADDRESS IF DEFFERENT: _____

CITY: _____STATE:_____ZIP CODE:_____

IN CASE OF EMERGENCY NOTIFY: _____

PHONE: (___) _____ RELATIONSHIP: _____

REFERRED BY: _____

INSURANCE:	Primary	Secondary
Insurance Company:	_____	_____
Subscribers Name:	_____	_____
ID Number:	_____	_____
Group Number:	_____	_____
Insurance Address:	_____	_____

Name: _____ **Date:** _____ **Eiriny Eskander, M.D.**

PATIENT MEDICAL INFORMATION FORM

PLEASE STATE MAIN REASON(S) OR MEDICAL CONCERNS FOR DOCTOR'S VISIT

_____

_____

_____

CURRENT and PAST MEDICAL HISTORY: (including Date of Onset)

- ☐ Hypertension: _____ ☐ Hypothyroid: _____
- ☐ Diabetes: _____ ☐ Depression: _____
- ☐ High Cholesterol: _____ ☐ Anxiety: _____
- ☐ Heart Attack : _____ ☐ Sleep Apnea: _____
- ☐ Degenerative Joint Disease: _____
- ☐ Others: _____
- ☐ _____
- ☐ _____

PAST SURGICAL HISTORY (if none, please write none)

- ☐ Gall Bladder Removal _____ ☐ Appendix _____
- ☐ Other: _____
- ☐ _____
- ☐ _____

MEDICATIONS: (name, dosage, frequency)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____
7. _____ _____
8. _____ _____

ALLERGY to Medications: _____

FAMILY MEDICAL HISTORY: (list medical conditions, e.g. heart attacks, stroke, cancer, dementia)

If no longer alive, age when deceased and cause of death

Father: _____ Mother: _____

Brother(s): _____ Sister(s) _____

Name: _____ **Date:** _____ **Eiriny Eskander, M.D.**

SOCIAL HISTORY:

Cigarette smoking: Yes ____ No ____ Cigarettes per day: _____ since what age _____

Past Smoker Yes _____ Age started _____ Age quitted: _____

Alcohol consumption: (# of drinks per day) _____

Marital Status: Married: ____ Divorced: _____ Single: _____ Other: _____

Number of Children: _____

Occupation: _____

WEIGHT HISTORY:

Weight in High School: _____ Highest Weight: _____

Commercial Program Tried: Weight Watchers: _____ Jenny Craig: _____ Lindora: _____

Diet Medications Tried: _____

REVIEW OF BODY SYSTEMS: (check any following symptoms that you experienced recently)

General:	fever ( )	chills ( )	night sweats ( ) weight gain ( )
Eyes:	blurred vision ( )	double vision ( ) seeing black or white spots ( )	
ENT:	ear-aches ( )	hearing problem ( )	
Cardio:	chest pain ( )	irregular heartbeats ( )	
Respiratory:	cough ( )	wheezing ( )	shortness of breath ( )
GI:	nausea ( )	vomiting ( )	heart burn ( ) constipation ( )
	diarrhea ( )	constipation ( ) gas and bloating ( )	
GU:	blood in urine ( )	pain with urination ( )	frequent urination ( )
Muscle/joint:	joint pain ( )	difficulty with movement ( )	
Mental:	anxiety ( )	depress feeling ( )	sleep problem ( )
Endocrine:	feel hot or cold ( )	hair Loss ( )	tired all the time ( )
Hematologic:	abnormal bleeding/clotting problem ( )		
Menstrual Cycle:	Regular ( )	Irregular ( )	Menopause ( )

Others: _____

_____

_____

HEALTH MAINTENCE (YEAR OF LAST EXAM):

Colonoscopy: _____ Mammogram: _____ Bone Density: _____

Vaccination: Flu _____ Tetanus _____ Shingles _____ Pneumovax

_____

Pharmacy Location: _____

Pharmacy Phone Number: (____): _____

DR. ESKANDER

Patient Contact Instruction

Patient Name: _____ Date of Birth:_____

How may we contact you regarding your future appointments, test results, etc.
Please check all we may do in the future:

- ☐ Speak *only* with you directly
- ☐ Leave phone message on your cell phone
- ☐ Leave phone message on your home phone
- ☐ Fax test results to you
- ☐ Email test results to you

  Note that our email server is *HIPPA Compliant*, if you would like to receive your results via email, please check the box above and provide your email here:

  _____

Please let us know if you also will allow us to speak with any of your family members regarding your health information? (please circle) **Yes / No**

If ***Yes***, please list the Names and Contact information of members:

Name: _____ Number: _____
Relation to you: _____

Name: _____ Number: _____
Relation to you: _____

Name: _____ Number: _____
Relation to you: _____

Name: _____ Number: _____
Relation to you: _____

_____ _____
Patient Signature Date

Request for medication refills protocol **Effective Date: 7/15/2011**

Dear Patients,

We would like you to help us facilitate your medication refill requests by the following procedure so we can process your request on a timely basis.

1. **First**, please **call your pharmacy** to send us a fax request(s) for the medication refills you need.

2. Please call your pharmacy **at least 5 days** before you run out of your medication. We would need a few days of turn around time due to the large number of requests we get everyday. We might not be able to process your request immediately.

3. **Restricted medications** such as narcotic pain medication, Adderall, Concerta, and Suboxone **can't be refilled via fax or over telephone**.
   This is a FDA regulation to avoid fraudulent prescriptions.
   You must be seen by our doctors in the clinic in order to obtain a paper prescription with original signature.

4. **Antibiotics** usually **can't be refilled** unless our doctors recently evaluated you for the same infection. Otherwise, our doctors need to see you in order to determine the nature of the infection and prescribe the appropriate medication

5. **Requests may be denied** for some medications because no recent labs or office visits. Many medications require regular monitoring for effectiveness of the medication on you health condition and potential side effect(s) on your body. Some examples, cholesterol meds., thyroid meds., mood (depression, anxiety) meds., blood pressure meds and diabetes medication.

6. If you weren't evaluated by our doctors within the last 3 months, we usually request that you come in for an appointment for evaluation and refill at the same time.

We appreciate your cooperation and understanding in helping us to accommodate your request(s) on a timely.

Dr. Eskander and our office staff. _____

Print Pt's Name: _____

Pt's signature: _____ Date: _____

Notice of Administrative Fees

Date: January 1st, 2011

Dear Patients,

Due to continue increase in our office's overhead and low insurance reimbursement from many of the insurance plans in California, we are no longer able to provide many administrative services free of charge.

Please be informed that you will be charged for the following administrative fees Effective as of January 1st, 2011.

1. Lab results; mail ($5) fax or e-mail (free of charge)
2. Medical records, 25 cents/page up to $50/record depending on the length of record.
3. Filling out forms and letters, $25 each page.

For example, DMV forms, excuse from Jury duties, disability forms, letters to airlines, letters to employers, letters to insurance companies and public agencies.

Would be $25 for each page per form.

4. "No show for scheduled appointment or cancellation less than 24 hrs notice"
   There is a $50 charge for our loss of the appointment time slot.

Thank you very much for your attention in this matter.

Dr. Eskander and administrative staff. _____

_____ _____

Print Patient's Name Date

_____

Patient's Signature

Patient Payment Responsibility

As a courtesy, our office will verify insurance coverage for our new patients. If we are contracted with your insurance, we will bill your insurance company on your behalf and only collect the amount deemed your responsibility by your insurance plan. This will include co-payment at the time of service and deductible/coinsurance or non-covered services determined by your policy with the insurance company.

The verification that we receive from your insurance plan is not a guarantee of benefits. ***It is the patient's responsibility to verify your Specialist Physician level benefits with your insurance company prior to your first appointment. We recommend you call your insurance company to determine coverage for visit with Dr. Eskander (Diabetes and Endocrine Specialists, Inc.)***

A co-payment is a per-person, per-visit amount that you are expected to pay before your insurance company begins covering the cost of your care. The required co-payment amount due by the patient is based on the contract you have with your insurance company, chosen by you or your employer.

Co-insurance is a form of medical cost sharing that requires an insured person to pay a stated percentage of medical expenses after the deductible has been met. The co-insurance percentage due by the patient is based on the contract you have with your insurance company, chosen by you or your employer.

A deductible is a fixed dollar amount during the benefit period that an insured person pays before the insurance company starts to make payments for covered medical services. Your insurance will not pay for any of the services we provide until your deductible has been paid by you.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical services, visits or tests ordered by the doctor or staff.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary may not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

If I am uninsured, I agree to pay for the medical services rendered to me at time of Service.

Print Patient's Name: _____

Patient's Signature: _____ Date:_____

Eiriny T. Eskander
Diabetes and Endocrine Specialists
16311 Ventura Blvd, Suite 850; Encino CA 91436
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Medication Refills and Follow Up:

Follow up is a necessary part of continuity of care and treatment. All medications prescribed need follow up labs and/or monitoring of vital signs and clinical evaluation to ensure it is improving your medical condition.

Depending on the patient's condition, Dr. Eskander will recommend a follow up plan. **We are unable to provide refills on medications if there is no consistent follow up or labs completed.**

Patient Name: _____

Patient Signature:_____

Date: _____

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Notice of Privacy Practices
Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Patient Name: _____

Patient Signature:_____

Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____