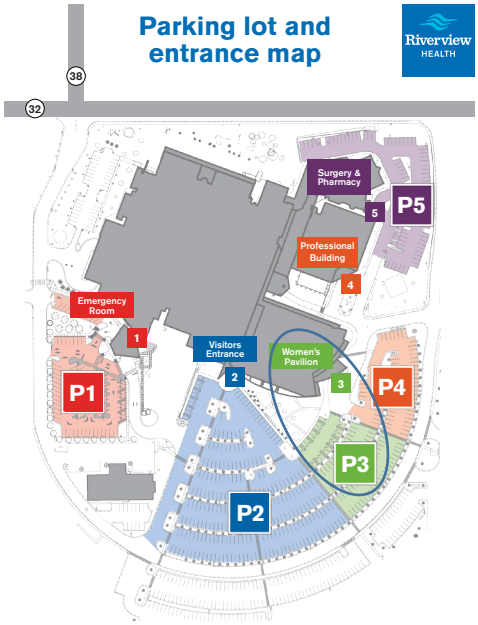
This is to confirm that _____ has an appointment at Riverview Health Noblesville Diabetes & Endocrinology on _____. Please arrive at _____ for a _____ appointment.

- ☐ Please complete the enclosed forms prior to your visit and bring them with you along with your insurance cards and picture ID.
- ☐ If your insurance company requires a referral, (we are specialists) you or your referring physician must obtain this prior to your appointment. It is very important for you to check with your insurance provider to make sure the provider you are about to see is a provider listed within your specific plan. Unfortunately, we are unable to verify this for you. We must have the authorization before you are seen
- ☐ **Please do not wear perfume or cologne** to your visit as we have staff and other patients with allergies and asthma.
- ☐ If you cannot make this appointment, please call us at least 24-hours in advance at 317.776.3520 so we may offer your appointment time to another patient waiting to be seen. Repeatedly missing appointments without calling to cancel is grounds for dismissal from our practice. Appointment reminder calls are made as a courtesy to our patients. However, it is the responsibility of the patient to keep track of the date and time of the scheduled appointment.

Your appointment is at the following location:

Noblesville Diabetes & Endocrinology
Women's Pavilion
395 Westfield Rd, Suite D
Entrance 3
Noblesville, IN 46060

Phone: 317.776.3520



Riverview Health Physicians

Patient Information

Patient Name: _____ Preferred Name: _____ Sex: _____

Date of Birth: _____ Social Security #: _____ Primary Care Physician: _____

Address: _____ City: _____

County: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____
Circle One Preferred Preferred Preferred

Preferred Language: _____ Interpreter needed: ☐ Yes ☐ No

Marital Status: Married, Single, Widowed, Divorced, Minor Spouse Name & Phone Number: _____
Circle One

Race: Caucasian, African American, Hispanic, Asian, American Indian, Other Ethnicity: Hispanic Non-Hispanic
Circle One Circle One

Preferred Method of Contact: Phone, Postal Mail, MyChart Email: _____
Circle One

Employer: _____ Employment Status: Full-time, Part-time, Retired
Circle One

Subscriber Demographics – Please Indicate if Same as Above and Don't Duplicate Information

Subscriber Name: _____ Date of Birth: _____ Relationship to Patient:_____

Address:_____

City: _____ State: _____ Zip:_____

Employer: _____ Employment Status: Full-time, Part-time, Retired
Circle One

Uninsured
I do not have insurance and understand that I am financially responsible for the charges incurred.

Patient/Guardian Signature: _____ Date: _____

Signature of Individual Completing Form

Signature: _____ Date: _____

Medical History Form

Name _____ Preferred Name _____ DOB _____

Referring MD _____ Primary Care Doctor _____

Pregnant / Planning to become pregnant / Breastfeeding _____

Medical Problems			Date of Onset/Details/Explanation
Diabetes	☐ No	☐ Yes	_____
Retinopathy	☐ No	☐ Yes	_____
Neuopathy	☐ No	☐ Yes	_____
Kidney Disease	☐ No	☐ Yes	_____
Foot Ulcers/Infection	☐ No	☐ Yes	_____
High Blood Pressure	☐ No	☐ Yes	_____
High Cholesterol	☐ No	☐ Yes	_____
Heart Disease	☐ No	☐ Yes	_____
Stroke/TIA	☐ No	☐ Yes	_____
Seizures	☐ No	☐ Yes	_____
Blood Clots/Bleeding Problems	☐ No	☐ Yes	_____
Liver Disease	☐ No	☐ Yes	_____
Cancer	☐ No	☐ Yes	_____
Asthma/Emphysema	☐ No	☐ Yes	_____
Thyroid Disease	☐ No	☐ Yes	_____
Pituitary Disease	☐ No	☐ Yes	_____
Adrenal Disease	☐ No	☐ Yes	_____
Autoimmune Disease	☐ No	☐ Yes	_____
Osteoporosis	☐ No	☐ Yes	_____
Arthritis	☐ No	☐ Yes	_____
Other	☐ No	☐ Yes	_____

Please list current medications/doses:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medical History Form

Drug Allergies

PCN ☐ No ☐ Yes - Reaction _____ Contrast Dye ☐ No ☐ Yes - Reaction _____

Sulfa ☐ No ☐ Yes - Reaction _____ Other _____ Reaction _____

Latex ☐ No ☐ Yes - Reaction _____ Other _____ Reaction _____

Social History

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Life Partner

Number of Children/Ages: _____

Sexual Orientation: _____ Gender Identification: _____

Occupation: _____

Tobacco Use: ☐ No ☐ Yes _____Times/Day Past Use: ☐ No ☐ Yes, I quit _____

Vape Use: ☐ No ☐ Yes _____Times/Day Past Use: ☐ No ☐ Yes, I quit _____

Alcohol Use: ☐ No ☐ Yes - Drinks/Week _____

Street Drugs: ☐ No ☐ Yes - Types/Frequency _____

Family History

		Family Member
Diabetes	☐ No ☐ Yes	_____
High Blood Pressure	☐ No ☐ Yes	_____
High Cholesterol	☐ No ☐ Yes	_____
Heart Disease	☐ No ☐ Yes	_____
Stroke	☐ No ☐ Yes	_____
Thyroid Disease	☐ No ☐ Yes	_____
Cancer	☐ No ☐ Yes	_____
Blood Clots/Clotting Disorder	☐ No ☐ Yes	_____

Other: _____

Please list previous surgeries:

_____

_____

Pharmacy Name/ Address: _____

_____

Name: _____ DOB: _____

Constitutional

- ☐ Change in Appetite
- ☐ Chills
- ☐ Excessive/Abnormal Sweating
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected Weight Change

ENT

- ☐ Trouble Swallowing
- ☐ Voice Change

Eyes

- ☐ Eye Itching
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Visual Disturbance
- ☐ Protruding Eyes
- ☐ Double Vision
- ☐ Loss of peripheral vision

Respiratory

- ☐ Stop breathing while asleep
- ☐ Excessive Snoring
- ☐ Cough (chronic)
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular

- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations
- ☐ Cramping in legs when walking
- ☐ Orthopnea (shortness of breath when lying flat)

Gastrointestinal:

- ☐ Abdominal Pain (chronic)
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Feeling full quickly when eating

Endocrine

- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Recurrent or Frequent Use of Steroids
- ☐ Use of male/female hormones
- ☐ Leaking of Milk/Fluid from Breasts

Genitourinary

- ☐ Difficulty Urinating
- ☐ Menstrual Problems
- ☐ Prostate Problems

Musculoskeletal

- ☐ Arthralgias (joint pain)
- ☐ Back Pain
- ☐ Myalgias (achy muscles)

Skin

- ☐ Color Change
- ☐ Women — Excessive Facial/Chest/Back Hair
- ☐ Excessive Acne
- ☐ Purple Stretch Marks

Neurological

- ☐ Dizziness
- ☐ Headaches
- ☐ Numbness
- ☐ Seizures
- ☐ Fainting
- ☐ Tremors
- ☐ Weakness
- ☐ Nerve Pain (burning or pins/needles)

Psychiatric

- ☐ Confusion
- ☐ Decreased Concentration
- ☐ Depression
- ☐ Nervous/Anxious
- ☐ Mood Swings

Other

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please list the names and phone numbers of physicians or providers you are currently seeing:

	Physician Name	Physician Phone Number
Primary Care		
OB/GYN		
Bariatric Surgeon		
Cardiologist		
Ear, Nose, Throat		
Gastroenterologist		
Hematologist		
Infectious Disease		
Nephrologist		
Neurologist		
Oncologist		
Ophthalmologist		
Orthopedist		
Pain Management		
Podiatrist		
Psychiatrist		
Pulmonologist		
Rheumatologist		
Surgeon		
Urologist		
Other		