DIABETES & ENDOCRINE CENTER OF ORLANDO, PA
3113 LAWTON ROAD, SUITE 100 - ORLANDO, FL 32803
(407) 894-3241

PERSONAL INFORMATION

First Name	Middle Name	Last Name	Preferred Name
Birthdate	Sex	Marital Status	Social Security Number (*required for insurance purposes*)
Race ☐ Asian ☐ African American ☐ Caucasian ☐ Chinese ☐ East Indian ☐Filipino ☐ Hispanic ☐ Japanese ☐Native American ☐ Other			Primary Language:
Street Address			
City	State	Zip	County
Mailing Address			
City	State	Zip	County
Home Phone	Work Phone		
Cell Phone	E-Mail Address		

HIPAA COMPLIANCE

What phone numbers may we call to discuss your medical care?	☐ **Home**	☐ **Cell**	☐ **Work**
Where may we leave a message on your answering machine or voice mail?	☐ **Home**	☐ **Cell**	☐ **Work**

PRIMARY CARE PHYSICIAN

Primary Care Physician		
Phone #	Fax #	
Address	City	Zip

IF YOU WERE REFERRED TO US, PLEASE LET US KNOW WHO REFERRED YOU?

☐ Primary Care Physician ☐ Hospital/ER ☐ Nurse/Hospital/Physician Staff ☐ Friend/Relative ☐Yellow Pages ☐ Other
Name:
Phone # (if a doctor)

PATIENT'S EMPLOYMENT INFORMATION

Employer	Occupation	
Street Address	Phone#	
City	State	Zip

SPOUSE INFORMATION

Name	Date of Birth
Cell Phone	Work Phone
May we discuss your medical care with your spouse? ☐ **Yes** ☐ **No**	

Who can we discuss your medical care with other than your spouse?

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

Emergency Contact- Person not living with patient (relative or friend)

Name	Relationship	Phone

PATIENT NAME ______________________________

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HEALTH INSURANCE INFORMATION

Primary Insurance Company	
ID#	
Policy Group #	Group Name
Subscriber's Name	
Subscriber's Birth date	Relationship to Patient
Subscriber's Social Security # *(required for insurance purposes)*	

Secondary Insurance Company	
ID#	
Policy Group #	Group Name
Subscriber's Name	
Subscriber's Birth date	Relationship to Patient
Subscriber's Social Security # *(required for insurance purposes)*	
If Medicare is secondary please specify the reason why:	

PHARMACY INFORMATION

Local Pharmacy	Phone #
Address	Fax#

Mail Order Pharmacy (example Medco or Express Scripts)	Phone #
	Fax#

Pharmacy for Diabetic Supplies (test strips and lancets)	Phone #
	Fax#

OTHER SPECIALISTS THAT YOU CURRENTLY SEE

SPECIALTY	NAME	PHONE #
CARDIOLOGY		
HEMATOLOGY/ONCOLOGY		
NEUROLOGY		
NEPHROLOGY		
OB/GYN		
OPTHALMOLOGY		
PODIATRY		
PSYCHIATRY		
SURGEON		

Signature:______________________________ Date:__________
(Patient and/or Responsible Party)