The Christ Hospital™ Health Network

The Christ Hospital Diabetes & Endocrine Center
Phone (513) 272-0313 Fax (513) 272-0316

Name: _____ Date of Birth: _____ Date: _____

Best daytime phone number: _____ Leave a message? Yes / No

Family physician: _____ Phone number: _____

Eye Doctor: _____ Phone number: _____

Last eye exam: _____

Consulting physician (if different from above): _____

Other physicians who need reports: _____

Prior Medical Problems (with approximate date of diagnosis): _____

_____

_____

_____

_____

_____

_____

Prior Hospitalizations/Surgeries (with approximate dates): _____

_____

_____

_____

_____

_____

_____

Family Medical History: (list chronic medical problems that each person may have)

Mother: _____ Father: _____

Children: _____ Siblings: _____

Mother's family: _____

Father's family: _____

Social History:

Married / Single / Widowed / Divorced / Partnered

Children: _____

How often do you exercise? _____

How much alcohol do you drink? _____

Do you smoke? No / Quit /Trying to quit / Yes

How much do you currently smoke? _____

How much did you used to smoke and when did you quit? _____

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Do you use any street drugs? No / Yes

If yes, please describe _____

Physician/NP signature _____ Date_____

Patient Name: _____ Date of Birth: _____ Date: _____

Current Medications (including over-the-counter medicines):

Name	Dose/times of day

Review of Systems: (please circle current problems)

General: ❑ weight gain ❑ weight loss ❑ chills ❑ fever ❑ fatigue

Ears/Nose/Throat: ❑ difficulty in swallowing ❑ change in voice ❑ sore throat

Eyes: ❑ vision loss ❑ double vision ❑ painful/itching eyes ❑ change in appearance of eyes

Endocrine: ❑ hot/cold intolerance ❑ increased urination breast discharge

Cardiovascular: ❑ chest pain ❑ irregular heartbeat

Respiratory: ❑ wheezing ❑ shortness of breath

Gastrointestinal: ❑ nausea ❑ vomiting ❑ diarrhea ❑ constipation ❑ abdominal pain

Genitourinary: ❑ painful urination ❑ irregular periods ❑ difficulty with erection

Musculoskeletal: ❑ bone pain ❑ muscle pain fractures ❑ change to ring or shoe size

Neurological: ❑ dizziness ❑ tremor ❑ headaches ❑ numbness/tingling

Skin: ❑ excessive sweating ❑ rash ❑ skin color changes ❑ flushing

Psychiatric: ❑ difficulty concentrating ❑ anxiety depressed mood

❑ All reviewed and negative except as noted above.

Physician/NP signature _____ Date_____

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THE CHRIST HOSPITAL DIABETES & ENDOCRINE CENTER

Patient Registration Information

Today's Date: _____

Patient Information: *(please print)*

Legal Name: _____
Last First Middle Initial

Social Security #: _____ Gender: M F Date of birth:_____

Maiden Name: _____ Other name(s) used/nicknames: _____

Address: _____
Number Street City State Zip

Home #: ( )_____ Work #: ( )_____ Cell #: ( ) _____

Email address: _____ Language spoken: _____

Need interpreter: Y N Marital Status: S M D W Separated Partner

Religion: _____ Ethnicity: Non-Hispanic Hispanic PCP: Dr. _____

Race: White African American American Indian Asian Native Alaskan Native Hawaiian Refused Other _____

Emergency Contacts: *please enter two*

Name: _____ Name: _____

Address/Zip: _____ Address/Zip: _____

Relation to patient: _____ Relation to patient: _____

Home #:( ) _____ Home #:( ) _____

Work #: ( ) _____ Work #: ( ) _____

Cell #: ( ) _____ Cell #: ( ) _____

Is there a: Legal Guardian: Y N Name: _____ POA: Y N Name: _____

Employment Information: Retired: Y N Date of retirement: _____

Patient's Employer:_____ Occupation:_____

Employer Address: _____ Full time: _____ Part time:_____
Number Street City State Zip

Insurance Information:

Primary Ins Name/Claims Address: _____

Policy/ID #: _____Group #: _____ Pt. relationship to subscriber: Self Spouse Child Other

Subscriber Info: Name: _____ DOB: _____ SSN: _____

Employer: _____ Full time:___ Part time:___ Work #: _____

Address: _____
Number Street City State Zip

Secondary Ins. Name/Claims Address: _____

Policy/ID #: _____Group #: _____ Pt. relationship to subscriber: Self Spouse Child Other

Subscriber Info: Name:_____ DOB:_____ SSN:_____

Employer: _____ Full time:___ Part time:___ Work #: _____

Address: _____
Number Street City State Zip

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THE CHRIST HOSPITAL DIABETES & ENDOCRINE CENTER

Today's Date: _____

Please print

Patient's Legal Name:
Last First Middle Initial

Date of birth:_____ SS #: _____

Do you have a Living Will: Y N Copy given to Primary Care Physician: Y N In chart: (office use only) Y N

Is there a Healthcare POA: Y N Name:_____ Relationship: _____

May we release test results to your:

Spouse Y N Name: _____

Parent Y N Name: _____

Child(ren) Y N Name: _____

Others Y N Name: _____

Name: _____

May we discuss billing questions with your:

Spouse Y N Name: _____

Parent Y N Name: _____

Child(ren) Y N Name: _____

Others Y N Name: _____

Name: _____

May we leave messages/test results on your answering machine? Y N Phone #: ( ) _____

May we call you at your place of employment? Y N Phone #: ( ) _____

The following may pick up my written prescriptions for controlled substances:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

We are legally required to provide you with a copy of our NOTICE OF PRIVACY PRACTICES the first time you receive care at TCHMA. If you are here for emergency medical treatment, you will be given a copy as soon as possible.

_____ I have received a copy of the Notice of Privacy Practices

_____ I have previously received a copy of the Notice of Privacy Practices

_____ I do not want a copy of the Notice of Privacy Practices

AUTHORIZATION

By signing below, I state the above information to be true and correct. I hereby authorize the physicians of The Christ Hospital Diabetes & Endocrine Center to treat the patient named in this document for medical and surgical procedures on scheduled or emergency basis, at any location and to submit a claim to my insurance carrier(s) or its intermediaries, to issue payment DIRECTLY to The Christ Hospital Diabetes & Endocrine Center on behalf of such rendered services. I understand that I am financially responsible to this The Christ Hospital Diabetes & Endocrine Center office for any balance not covered by my insurance carrier. A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

The Christ Hospital Health Network

The Christ Hospital Diabetes & Endocrine Center
4440 Red Bank Expressway Suite 210
Cincinnati, OH 45227
Phone: (513) 272-0313 | Fax: (513) 272-0316
Amanda Queen MD
Katherine Miller MD
Shannon Haggerty MD
Meenakshi Iyer MD
Barbara Ramlo-Halsted MD
Susannah Becker MD
Shawn Peavie DO
Lisa Zapf CNP
Katie Dinh CNP
Mary Ellen Adams CNP

From I-71 North/South
Take exit 9 for Red Bank Road. You will merge onto the Red Bank Expressway. Travel approximately 1.4 miles and the office will be on your left after the train overpass. *(Behind Penn Station/Next to the Gorilla Glue factory)*

From the East:
Take Beechmont Avenue/OH-125 over the levy. Turn right onto Beechmont Circle. You will then make a slight right onto Wooster Pike. Turn left at Red Bank road. The office will be on your right before the train over pass. *(Behind Penn Station/ Next to Gorilla Glue factory)*

From the West:
Take I-75 to exit 7 for OH-562 toward I-71/Norwood. Take the I-71 North exit toward Columbus. You will be entering from the left, but will need to exit on the right in about 0.5 miles from exit 9 for Red Bank Road. You will merge onto the Red Bank Expressway. Travel approximately 1.4 miles (4 stop lights turn left) and the office will be on your left after the train overpass. *(Behind Penn Station/Next to the Gorilla Glue Factory)*

From Dayton:
Take I-75 South to exit 16 for I-275 toward I-71/Columbus. Keep left at the fork to continue on I-275 East. Take exit 49 for I-71 South. Take exit 9 for Red Bank Road. You will merge onto Red Bank Expressway. Travel approximately 1.4 miles(4 stop lights, turn left) and the office will be on your left after the train overpass. *(Behind Penn Station/Next to the Gorilla Glue factory)*

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Welcome to our practice. The doctor will need a complete list of any medication, vitamins or herbs you are currently taking. If you are a diabetic patient please bring your glucose meter, and any logs you have kept to your visit. **It is important to have your past medical records from your primary care physician or specialist physician to us at least one week prior to your appointment.** Please contact your doctors office and have those records faxed to us at 513-272-0316. Without these records we may order tests that were previously performed which could result with your insurance not fully paying for these services to be performed again.

Enclosed are driving directions from most major highways and new patient paperwork that needs to be completed and brought with you to your appointment.

If you need to cancel your visit, please call us at 513-272-0313, we require a 24 hour advance notice of cancelations or a fee of $100.00 may be accessed. This is not payable by insurance.

Thank you for choosing The Christ Hospital Diabetes and Endocrine Center, we look forward to seeing you!

PLEASE MAIL BACK COMPLETED PACKET TO:
THE CHRIST HOSPITAL DIABETES & ENDOCRINE CENTER
4440 RED BANK EXPRESSWAY
SUITE 210
CINCINNATI, OHIO 45227