Triumvirate
MEDICAL GROUP

Patient Name_____ Date of Birth _____

Address _____ City _____ State ____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email _____

Marital Status _____ Gender _____ Race _____ Ethnicity _____

Employer Name _____ Occupation _____

Emergency Contact Name _____ Phone_____ Relationship _____

Local Pharmacy Name _____ Local Pharmacy Number _____

Mail Away Pharmacy Name _____

Guarantor (Person to be billed if other than patient) _____

Address _____City _____ State _____ Zip _____

Phone _____ Relationship to patient _____

I authorize Triumvirate Medical Group to submit claims to my insurance carrier and accept payment for services rendered to me. I understand that I am liable for any billable service rendered. I authorize direct payment to be made.

Patient (Legal Representative) Signature _____ Date _____

If Legal Representative, please indicate relationship to patient _____

Patient Communication Preferences

I prefer to have my appointment confirmed by (choose one)

○Email ○Cell Phone ○Home Phone ○Work Phone

I authorize Triumvirate Medical Group physicians and staff to (please check all that apply)

☐Leave detailed messages including medical information on my cell phone

☐Leave detailed messages including medical information on my work phone

☐Leave detailed messages including medical information on my home phone

☐Discuss my medical care with the following people

Name _____ Phone _____Relationship _____

Name _____ Phone _____Relationship _____

Signature _____

Endocrinology Associates
OF PRINCETON, LLC

Name_____ Age_____ Date of Birth _____
Referring Physician _____Primary Care Physician_____
Other Physicians _____
How did you hear about us? _____
Reason for visit _____ Date of visit _____

Please only complete the section that pertains to your visit

Thyroid Hormone Dysfunction

Year Diagnosed _____ Is your thyroid ○Underactive ◉Overactive
Type of treatment received _____

Thyroid Nodules

Year Diagnosed _____ How were they found? _____
Have you had a biopsy? ○Yes ○No Results? _____
When was your last Ultrasound? _____

Thyroid Cancer

Year Diagnosed _____ Last Ultrasound _____ Last whole body scan_____
Treatment ☐Surgery Date_____ Details: _____
☐Radioactive Iodine Date_____ Details: _____
☐Add'l treatment Date_____ Details: _____
Any additional imaging (CT scan, PET, Xray) _____

Diabetes

Year Diagnosed _____ If on insulin, date started: _____
If you check your blood sugars… Fasting range _____ Post meal range _____
Do you get many low sugars? _____
Do you have (check any that apply)
☐Heart Disease ☐Kidney Disease ☐Diabetes Eye Disease
☐Numbness or Tingling in Feet (Neuropahty)

Osteoporosis

Year Diagnosed _____ Date of last Bone Density _____
Have you had a fracture? ○Yes ○No Date _____ Treatment _____
Which medications have you used in the past? _____

Other Endocrine Concerns

☐Pituitary Disease ☐Adrenal Disease ☐Polycystic Ovarian Syndrome ☐Trangender
☐Other _____
Year Diagnosed _____Previous Imaging (MRI, CT Scan)_____
Previous treatment (including surgeries) _____

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Please list all prescription and over the counter medications/supplements you are taking

Medication	**Dosage**	**How Often**	**Date Started**

Please list your chronic medical conditions (ie high blood pressure, thyroid disease, diabetes)

Medical Condition	Date Diagnosed	Physician

Please list any allergies

Drug	
Food	
Environmental	

Please List Previous Surgeries or Hospitalization

Reason for Surgery or Hospitalization	**Date of Surgery or Hospitalization**

Please describe the following habits

Tobacco	◯ Never	◯ Previously	◯ Rarely	◯ Occasionally	◯ Daily
Alcohol	◯ Never	◯ Previously	◯ Rarely	◯ Occasionally	◯ Daily
Recreational Drugs	◯ Never	◯ Previously	◯ Rarely	◯ Occasionally	◯ Daily

Please list any medical conditions in your family

Family Member	**Living**	**Deceased**	**Age**	**Diseases**
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Gradnfather				
Sibling				

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Authorization to Release Information

I hereby authorize Triumvirate Medical Group to furnish all necessary information they may have regarding my condition under their observation or treatment, including the history obtained, radiology, laboratory, physical findings, diagnosis and prognosis to my insurance company(ies) and/or physicians.
Initials _____

Assignment of Benefits & Payment Responsibility

I hereby assign all medical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and any other health plans to Triumvirate Medical Group. This assignment will remain in effect until revoked by med in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize assignee to release all information necessary to secure payment.
Initials _____

Receipt of Privacy Practices

I have received a copy of Triumvirate Medical Group's Notice of Privacy Practices.
Initials _____

Eligibility Waiver

I understand that my eligibility for coverage may not be able to be confirmed at this time. I wish to receive medical service from Triumvirate Medical Group. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.
Initials _____

Prescription Medication Consent

Triumvirate Medical Group uses an electronic medical record system that allows electronic prescribing of medications. This is utilized to ensure accurate medication information and to coordinate medical care. I consent to allow my provider to electronically access my medication history.
Initials _____

I have read and agree to all statements, terms and conditions above.

Signature of Patient or Legal Guardian _____

Patient Name _____ Date _____

Legal Guardian Name _____ Relationship _____

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Financial Policy

Along with providing quality healthcare to our patients, it is very important to explain the financial expectations of the doctor/patient relationship.

Insurance Coverage and Billing: We ask that you bring your Insurance Card to **all** visits. If we participate with your insurance carrier we will bill them directly for services provided. We assume no responsibility for services denied by your insurance plan. Coverage of services varies widely amongst insurance plans. We encourage you to contact your benefits representative to verify coverage before receiving services in our office. If our practice does not participate with your insurance plan you will be responsible for payment for services provided at the time of your visit. We will provide you with documentation to submit to your insurance company for reimbursement.

Referrals: If your insurance requires referrals for your visit, it is the responsibility of the patient to ensure that there is an up to date referral prior to their appointment. If an active referral is not available at the time of your visit you will need to reschedule your appointment.

Choosing a Primary Care Physician: If Triumvirate Medical Group serves as your Primary Care Provider you may need to notify your insurance provider. Many insurance plans require patients to elect a Primary Care Doctor prior to the first visit. Failure to notify your insurance company about a change in your Primary Care Provider may result in insurance not covering your visits.

Copays: All copays must be paid at the time of visit. This arrangement is part of your contract with your insurance company.

Deductibles: Many insurance plans now have deductibles. If you have not met your deductible you will be billed for services provided as determined by your insurance company.

Returned Checks: All returned checks are subject to a $25 fee payable to Triumvirate Medical Group in addition to any bank fees incurred.

No Show Policy: We have set aside a specific amount of time for each of our patients. We understand that late cancellations may be unavoidable. However, these appointment times go unutilized by our other patients. Appointments that are cancelled without 24 hour notice are subject to a No Show Fee in accordance with the level of service. You will be charged $50 for initial visits, routine preventive visits and procedures. The remainder of the visits will be subject to a $25 fee.

I have read and understand the Financial Policy.

Patient Name _____ Date of Birth _____

Patient (Legal Representative) Signature _____ Date _____

If Legal Representative, please indicate relationship to patient _____