

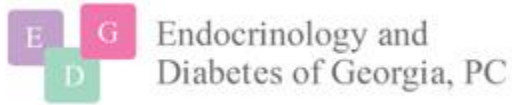
5400 Laurel Springs Pkwy, Suite 601
Suwanee, GA. 30024
Phone : 770 754 1600
Fax : 770 754 1605

Welcome to Endocrinology and Diabetes of Georgia, PC

- Please be sure to **completely fill out** all paperwork pertaining to your visit. **This paperwork must be completed prior to being seen.** Please keep all paperwork **SINGLE SIDED** to scan your information into our Electronic Medical Record system.
- Please bring in your written referral or have the referring physician fax your referral if one is required with your insurance. Please refer to our insurance referrals policy in the new patient packet.
- Please call your insurance carrier and confirm that our provider, **Dr. Vijayasudha Gunna, MD.**, is an In-Network Provider on your plan. All out of network visits will be billed as such. Please refer to our insurance carriers policy in the new patient packet
- We draw labs in the office through LabCorp. Some insurance may not be covered under this lab. If you are unsure which lab your insurance company requires, please call your insurance company prior to your visit. **Unless otherwise noted, all labwork will be processed and billed through Labcorp.** It is the patient's responsibility to notify the office of alternate labs required by their insurance. Please refer to our financial agreement in the new patient packet.
- Please bring any recent lab work with you or have the referring physician fax your most recent labs to our office. You will find a medical release form at the end of this packet. **These records are REQUIRED for all new patients that are being seen in our office.** Lack of records will delay your visit. Please refer to our medical records release form in the new patient packet.
- Please bring your current insurance card along with a valid driver's license or another valid, unexpired photo ID.
- Co-pays or coinsurances will be collected at the time of your visit. Endocrinology and Diabetes of GA, PC is considered a **SPECIALIST VISIT** through all insurances. We recommend that you check with your insurance company if you are unsure of the amount due. Please refer to our financial agreement in the new patient packet.
- If you need to cancel your appointment, we require a 24 hour notice. All cancellations less than 24 hours will result in a \$25.00 fee. Please refer to our cancellation policy in the new patient packet.

WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND DISCOVER
WE DO NOT ACCEPT AMERICAN EXPRESS

*Thank you,
Endocrinology and Diabetes of Georgia, PC*



Endocrinology and
Diabetes of Georgia, PC

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PATIENT INFORMATION

Name: _____ SEX: M F DATE OF APPT _____

ADDRESS: _____

HOME PHONE: _____ CELL PHONE _____ ALTERNATE PHONE _____

MOBILE PHONE CARRIER: _____ (THIS IS FOR TEXT NOTIFICATIONS FOR FUTURE APPTS ONLY)

EMAIL ADDRESS(Please print clearly) _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY CARE/REFERRING PHYSICIAN INFORMATION

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

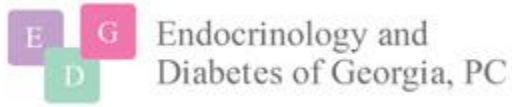
DATE LAST SEEN: _____

REFERRING PHYSICIAN (IF DIFFERENT THAN PRIMARY) _____

ADDRESS: _____

PHONE: _____ DATE LAST SEEN: _____

PATIENT SIGNATURE _____ DATE _____



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INSURANCE INFORMATION

PRIMARY INSURANCE

ADDRESS: _____

MEMBER ID# _____

GROUP# _____

COPAY \$/COINSURANCE %(IF LISTED ON CARD) _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____ SUBSCRIBER SOCIAL SECURITY # _____

SECONDARY INSURANCE

ADDRESS: _____

MEMBER ID# _____

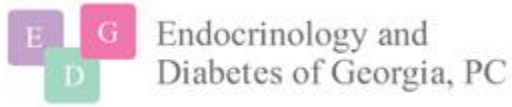
GROUP# _____

COPAY \$/COINSURANCE %(IF LISTED ON CARD) _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____ SUBSCRIBER SOCIAL SECURITY # _____

PATIENT SIGNATURE _____ DATE _____



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MEDICAL HISTORY

PATIENT NAME: _____ DOB: _____

REASON FOR YOUR VISIT

[Please circle appropriate choice(s)]

THYROID

DIABETES

PCOS

HORMONE ISSUE

TESTOSTERONE

NUTRITIONAL COUNSELING

SURGERY/HOSPITALIZATIONS

REASON	HOSPITAL	DATE

HEALTH MAINTENANCE

(LIST DATE/YEAR/FACILITY)

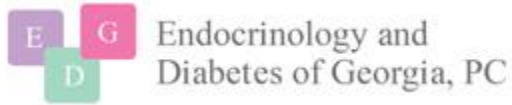
MAMMOGRAM: _____ COLONOSCOPY _____

BONE DENSITY SCAN: _____ THYROID ULTRASOUND: _____

EYE EXAM: _____ FOOT EXAM: _____

THYROID BIOPSY: _____ THYROID NUCLEAR SCAN: _____

PATIENT NAME _____ DOB: _____



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MEDICATION LIST

MEDICATION NAME

DOSE/STRENGTH

DATE LAST FILLED

MEDICATION NAME	DOSE/STRENGTH	DATE LAST FILLED

PHARMACY INFORMATION

LOCAL PHARMACY NAME: _____ **PHARMACY PHONE:** _____

PHARMACY ADDRESS: _____

MAIL ORDER PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE: _____

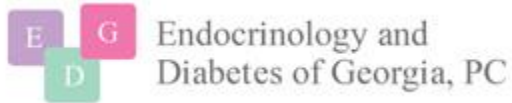
ALLERGIES

Medication: _____ **Reaction:** _____

Medication: _____ **Reaction:** _____

Food: _____ **Reaction:** _____

PATIENT NAME: _____ **DOB:** _____



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HEALTH HABITS

SMOKING/CHEWING TOBACCO: YES NO YEARS: _____ PACKS/AMOUNT DAILY# _____

CAFFEINE BEVERAGES _____ AMOUNT DAILY# _____

RECREATIONAL DRUGS _____ AMOUNT DAILY# _____

ALCOHOLIC BEVERAGES _____ AMOUNT DAILY# _____

EXERCISE: _____ AMOUNT WEEKLY# _____

AVERAGE HOURS OF SLEEP: _____

WEIGHT LOSS OR GAIN IN LAST YEAR YES NO TOTAL AMOUNT# _____

SOCIAL HISTORY

MARRIED/ SINGLE/DIVORCED/WIDOWED/OTHER

NUMBER OF CHILDREN/AGES _____

OCCUPATION _____

INCREASED STRESS/MAJOR LIFE CHANGES: _____

PATIENT NAME: _____ DOB: _____

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FAMILY HISTORY

(PLEASE LIST ANY KNOWN DISEASES/RELATIONSHIP TO PATIENT)

MOTHER/MATERNAL FAMILY _____

FATHER/PATERNAL FAMILY _____

SIBLINGS _____

PATIENT NAME _____ **DOB:** _____

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REVIEW OF SYSTEMS

(circle all that apply)

GENERAL

Fever
Fatigue
Difficulty sleeping
Weight gain
Weight loss

PULMONARY

Cough
Emphysema
Bronchitis
Asthma
TB Skin Test

EENT

Change in vision
Color Blindness
Peripheral Vision Change
Motion Sickness
Allergies/Hay Fever
Difficulty Swallowing
Change in Voice

NEUROLOGICAL

Weakness
Stroke/Paralysis
Numbness/Tingling
Tremor
Headaches
Anxiety/Depression

Phobias
Hallucinations
Psychiatric Treatment
Vertigo

URINARY

Urination at night
Painful Urination
Urgency
Excessive Urination
Kidney Stones

MUSCULOSKELETAL

Pain in muscle/joints
Joint Swelling
Muscle Cramps
Arthritis
Back Pain

CARDIOVASCULAR

Palpitations
Chest Pain
Heart Disease
Heart Murmur

ENDOCRINE

Change in Hand Size
Change in Shoe Size
Abnormal Sweating
Excessive Thirst
Sugar In Urine
High/Low Calcium
Change in Appetite
Changes In Hair
Cold/Heat Intolerance
Head Neck Irradiation
Thyroid Disorder
Enlarged Thyroid

Changes in Breasts
Osteoporosis
Bone Fractures

SKIN

Color/Texture changes
Change in hair/nails
Rash/Itching
Easy Bruising
Acne

MALE REPRODUCTIVE

Prostate Cancer
Lack of Sexual Drive
Difficulty with Erections
Impotence
Penile Discharge
Prostatitis

GASTROINTESTINAL

Heartburn
Food/Lactose Intolerance
Nausea/Vomiting
Excessive Belching
Bloating
Hepatitis
Jaundice
Pancreatitis
Diarrhea
Constipation

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DIABETES HISTORY

When was Diabetes diagnosed: _____

Which meter is used to check blood sugars: _____

How often are readings done: _____

Average fasting reading _____

Average 2hour post meal reading _____

Describe dietary habits: _____

Concerns/Questions about Diabetes: _____

CURRENT SYMPTOMS

(Please circle all that apply)

Excessive Urination

Nighttime Urination

Low/High Blood sugar

Slow Healing

Excessive Thirst

Headaches

Night Sweats

Vision Issues

Diarrhea

Tingling/Numbness/Burning in Hands/Feet

Babies over 9lbs at birth

PATIENT NAME: _____ DOB: _____

THYROID HISTORY

When was thyroid condition diagnosed _____

Family History of Thyroid Conditions

(Please circle all that apply)

HYPOTHYROIDISM

HYPERTHYROIDISM

THYROID NODULEs

THYROID CANCER

GOITER

THYROID SURGERY

GRAVES' DISEASE

CURRENT SYMPTOMS

(Please circle all that apply)

Difficulty Swallowing

Hoarseness

Change in Nail/Hair

Weight Issues

Racing Heart/Palpitations

Change in Bowels

Fatigue

Depression

Concentration Issues

Change in Menstrual Cycle

Protruding Eyes

Vision Issues

Hot or Cold Body Temperature

PATIENT NAME: _____ DOB: _____

MENSTRUAL HISTORY

(IF APPLICABLE)

MENSTRUAL CYCLE

Cycle Frequency: _____ Duration of cycle: _____

Flow: Heavy Normal Light Spotting Last Pap Smear: _____

Other associated symptoms during cycle: _____

Date of last cycle: _____ Age cycle began: _____

Number of missed cycles in the last year: _____

Hysterectomy: YES NO Date _____ Ovaries removed: YES NO Date _____

Tubal Ligation YES NO Date _____

PREGNANCIES

Pregnancies#: _____ Live births#: _____ Weeks at Delivery: _____

Abortions#: _____ Miscarriages# _____

Premature births#: _____ Weeks at Delivery: _____

Complications of pregnancies/deliveries: _____
