NEW PATIENT FORM

Prior to your appointment date, please complete and email to welcome@endodw.com

Today's Date:	Name of person completing form:	Relationship to patient:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Nickname:	Gender

Date of Birth:	Age:	Race/Ethnicity:	Preferred Phone #:

Preferred Mailing Address:			
City:	State:	ZIP Code:	Preferred email:

Mother's Name:	Email:	Cell#:
Father's Name:	Email:	Cell#:

CONSULTATION/REFFERING PHYSICIAN INFORMATION:

Referred to ENDO Diabetes & Wellness by:	Name of Primary Physician (if different from referring name):	Name of Practice of Primary Physician:
Phone of Primary Physician:	Fax of Primary Physician:	Location (City, State of Primary Physician:

Why did you bring your child to the ENDO Diabetes & Wellness?

INSURANCE INFORMATION

Reminder: ENDO Diabetes & Wellness does not currently maintain contracts with insurance providers. Reimbursement of any service provided is at the discretion of your insurance company under the terms of your agreement. *This information is requested for scheduling procedures, laboratory exams, prior-authorizations forprescriptions, supplies, medical equipment, etc*

Primary Insurance Company:	ID#:	Group #:	Effective Date:
Name of Insured:	Date of Birth of Insured:	Insurance Company Address:	Insurance Phone:

IMPORTANT MEDICAL INFORMATION & RECORDS TO SUBMIT OR BRING TO YOUR APPOINTMENT:

☐ Copy of Growth Chart	☐ Recent/relevant lab work	☐ Recent/relevant medical notes from referring physician	☐ Relevant imaging studies (ie, Bone Age if applicable)	☐ Copy of Insurance card (Front and Back)