West Plano Diabetes and Endocrine Center, PA
6124 W Parker Rd, Suite 332
Plano, Texas 75093

PATIENT INFORMATION

Please return this page as soon as you are done with it.

If you would like to add an email address for appointment reminders and PHR please do so below.

***Patient Name**____
(Last) (First) (Middle)

Address____
(Street) (City) (State) (Zip)

Home Phone_____________________________ **Work/Cell Phone**_______________________________

Date of Birth____/_____/_____ **SSN**____________________________________

Gender **M** **F** **Marital Status (circle one)** Single Married Widowed Divorced Separated

Drivers License Number _________________________ **State DL issued** _______

***Occupation**_________________________ **Employer**____

Employer Address______________________________ **Employer Phone**________________________

***Emergency Contact**____________________________________ **Relationship**________________________

Address____

Home Phone____________________ **Cell Phone**__________________ **Work Phone**__________________

Race- Please circle the appropriate choice: *American Indian or Alaska Native *Asian *Black or African American *Hispanic or Latino *Native Hawaiian or Pacific Islander * White/Caucasian (non-Hispanic)

(Federal government regulations now require the following specific questions be asked concerning race)

***Pharmacy Information**: Local & Mail order pharmacy name, address, zip code and phone number

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***Preferred Lab**:____

***Primary Care Provider** ________________________________ **Phone number** _____________________________

***How did you hear of us?** *Website *Other Internet/web *Advertisement *Phone directory

*Friend/Relative/Acquaintance *Insurance plan *Referral service *Other _______________________

If physician referral: Provider name ____________________________________ **Phone** _________________________

E-mail Address:____

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Health Insurance Information

***Primary Insurance Name and Phone Number** ____

Group number ___________________________ **Member ID number** ____

Insured/Policy Holder name ____ **DOB** _____________________

***Secondary Insurance Name and Phone Number** ____

Group number ___________________ **Member ID number** ____

Insured/Policy Holder name ____ **DOB** _____________________

West Plano Diabetes and Endocrine Center

General Questionnaire

Your name:____

Hospitalizations:

Reason	**Year**	**Reason**	**Year**

Current Medications:

Name	**Dose**	**Freq.**	**Date Began**	**Name**	**Dose**	**Freq.**	**Date Began**

Medication Allergies:	**Symptoms**	**Medication Allergies:**	**Symptoms**

Allergies other than to medications:____

Family History:	Dad	Mom	Siblings	Children	Other
Diabetes					
Thyroid					
Cancer/Type					
Heart Disease					
Other					

Social History:

Current smoker: Y/N Packs per day:_______________ How long:_________________________________

Prior smoker: Y/N Packs per day:_______________ How long:_____________ Stopped:____________

Current alcohol: Y/N Drinks per day:_______________ How long:_________________________________

Prior alcohol: Y/N Drinks per day:_______________ How long:_____________Stopped:____________

Marital status:___________ Do you have children and how old are they?____________________________

Women:

Date of last menstrual period:______________________

Hysterectomy: Y/N Date:________________ Ovaries removed: Y/N