APPT TYPE: DIAB   ENDO   APPT DATE/TIME: _____   EID:

NEW PATIENT INFORMATION FORM   Appt Req Date (& time):

PATIENT'S NAME *(First and Last)*	
Optional: DOES PATIENT HAVE A NICKNAME?	
GENDER & DATE OF BIRTH	
CALLER'S NAME *(First, Last & Relationship)* *(i.e.: Mom, Dad, Grandmother/father, etc.)*	
BEST CALLBACK NUMBER: *(use for both to home & mobile)*	Cell?

⭐ **ENTER THE ABOVE INFO, ON LEFT: CHECK CONSENT TO TEXT, CHECK BOX "NO PATIENT EMAIL" & COMPLETE DEMOGRAPHICS
ON RIGHT: CHOOSE PROVIDER, DEPARTMENT, CONSENT TO CALL, & GUARANTOR. THEN SCHEDULE THE PATIENT.
AFTER SCHEDULED, GATHER THE REST OF THE BELOW INFO, AND END THE CALL. YOU CAN ENTER THIS INFO AFTER ENDING THE CALL.**

REASON FOR VISIT/CHIEF COMPLAINT:	
PATIENT'S HOME ADDRESS	
BEST EMAIL ADDRESS	
PRIMARY CARE PHYSICIAN / LOCATION (City, State)	
Optional: REFERRING PHYSICIAN -- (if not PCP) LOCATION: (City, State)	
OTHER PARENT'S NAME *(First, Last & Relationship)*	
OTHER PARENT'S BEST CONTACT PHONE NUMBER (*for emergency purposes*)	Cell?
DOES PATIENT LIVE WITH BOTH PARENTS? *(if not, with whom does child reside?)*	
Optional: ANY RESTRICTIONS ON NON-CUSTODIAL PARENT?	
PRIMARY INSURANCE (company)	
POLICY/MEMBERSHIP/SUBSCRIBER/ENROLLEE ID NUMBER	
GROUP NUMBER (if any) & TYPE OF PLAN (HMO/PPO/etc.)	
PRIMARY SUBSCRIBER'S NAME & DATE OF BIRTH	
IS THERE A SECONDARY INSURANCE? *(If so, include details)*	

ADDITIONAL NOTES, IF NEEDED

T1 Diabetics ONLY: Date of diagnosis (approximate): _____

Approximate date of last Diabetes appointment: _____ Previous provider: _____

Is patient on a pump? If so what kind: _____ Does patient use a CGM? If so what kind: _____