Date _____/_____/_____ Chart No. __________________

RALEIGH ENDOCRINE ASSOCIATES

ENDOCRINOLOGY, DIABETES & METABOLISM

Name ____ E-Mail ____

Date of Birth _____/_____/_____ Sex: Male / Female Social Security Number: _________________________

Mailing Address ____ Apt#______________________

City____ State _________________ Zip Code______________________

Preferred Phone (_____)-______-________ Home Phone (_____)-______-________ Cell Phone (____)-______-_______

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Preferred Language ____________________ Race ______________________ Ethnicity ________________________

Employer____ Employer Phone No.______________________________

Name of Parent / Guardian with whom the patient resides (if minor) ____

Emergency Contact ____

Relationship____ Phone No.____

Referring Physician ____ Phone No. _______________________________

Address ____ City __________________________ State________________

Primary Care Physician ____ Phone No. ________________________________

Address ____ City __________________________ State ________________

Pharmacy ____ Phone No. ________________________________

Address ____ City __________________________ State ________________

My signature below indicates that all information I have given is correct and accurate to the best of my knowledge.

AUTHORIZATION TO RELEASE INFORMATION**:** I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to the Health Center Financing Administration and its agents and to specific insurance carriers, third party payers or others involved in processing and collecting of any claims needed to determine these benefits or benefits for related services.

Date _____/_____/_____ Signature ____