SONORAN
Pediatric Endocrinology & Diabetes Institute, PLC

Patient Registration Form

Who is accompanying the patient today?________________________ Relationship to patient:____________________ Do you have legal decision making power?__________

Last Name:____________________ First Name:_________________ Middle Initial:______
Sex:____Male_____Female Date of Birth:_________ SS#:_________________
Street Address:___________________ City:____________ State:___________
Zip Code:_______ Work Phone:________________ Mobile Phone:_________________ Home Phone:_____________________ Race(Check One)_____IndianAmerican/AlaskanNative ______Asian/Oriental_______Black/African American______Native Hawaiian/Pacific Islander_______White______Other_____Declined Ethnicity(Check One)
Central American_____Cuban____Dominican_____Hispanic/Latino_____Mexican_____Puerto Rican_____South American_____Spainard_____Not Hispanic/Latino_____Other____Declined
Marital Status:____Single_____Married____Other(Widow,Divorced,Separated)
Spouses Name:________________ Spouses Employer:______________ Spouse's Employer Phone:________________ E-Mail Address:_____________________________
Patient PCP:____________________ Patient Referred By:___________________
Preferred Pharmacy (Location& Phone Number)____________________________________

Guardian Information(If Applicable)
Last Name:___________________ First Name:___________________ Middle Initial:______
Date of Birth:____________ Street Address:____________________ City:_________ State:_________ Zip Code:______
Phone #:____________________ SS#________________ Employer:______________
Employer Address:___________________ Employer Phone:__________________

Emergency Contact Information
Last Name:____________________ First Name:____________________ Phone #:___________ Relationship to Patient:___________________

Employer Information
Employer Name:_______________________________ Employer Phone Number:_____________________
Address:________________________ City:___________________ State:_____________ Zip Code:_________

Guarantor Information
Last Name:_____________________ First Name:_______________ Middle Initial:__________
Phone#:________________ SS#:_______________________ Date of Birth:____________ Street Address:_________________ City:_____________ State:_____________ Zip Code:___________
Employer Name:___________________ Employer Address:___________________________
Employer #:___________________

Insurance Information
Insurance Plan Name:__________________ Insurance Phone #:_________________ Policy ID#:____________
Policy Group#:______________

SONORAN
PEDIATRIC ENDOCRINOLOGY & DIABETES INSTITUTE, PLC

Aruna D Poduval, MD
Pediatric Endocrinologist

Francine Marran, RN, CDE
Registered Nurse, Certified Diabetes Educator

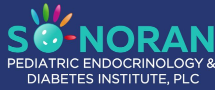
Medical History Form

Name:	**DOB:**

PLEASE CIRCLE ALL THAT APPLY

Adrenal Disease	Y	N	Headaches/Migraine	Y	N
Allergies	Y	N	Hearing Loss	Y	N
Anemia	Y	N	Heart Disease	Y	N
Asthma	Y	N	Heart Rhythm Disorder	Y	N
Autoimmune Disease	Y	N	Hypertension	Y	N
Blood Disorder	Y	N	Hyperlipidemia	Y	N
Bone/Calcium Disorder	Y	N	Kidney Disease/Stones	Y	N
Coronary Artery Disease	Y	N	Liver Disease/Hepatitis	Y	N
Developmental Disorders	Y	N	Lung Disease	Y	N
Depression	Y	N	Menstrual Disorder	Y	N
Diabetes, Type 1 or 2	Y	N	Mental Illness	Y	N
Diabetic Complications	Y	N	Nerve Disease	Y	N
Endocrine Disease	Y	N	Osteopenia/Osteoporosis	Y	N
Eye Problems	Y	N	Overweight/Obesity	Y	N
Failure to Thrive	Y	N	Pituitary Disease	Y	N
Gastritis/Ulcer	Y	N	Pneumonia	Y	N
GERD/Acid Reflux	Y	N	Polycystic Ovarian Syndrome (PCOS)	Y	N
Pre-Diabetes	Y	N	Underweight	Y	N

2204 S. Dobson Rd. STE 103
Mesa, AZ 85202
T: 480-757-6457
Fax: 1-844-201-3081
www.spedihealth.com



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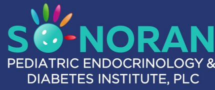
Premature Birth	Y	N	Urinary Problem	Y	N
Pubertal Disorder	Y	N	Viral Disease	Y	N
Thyroid Disease	Y	N	Palpitations	Y	N
Tuberculosis (or Positive TB Test)	Y	N	Vascular Heart Disease	Y	N
Turner Syndrome	Y	N	Other:	Y	N

Past Surgical History

Surgery	Reason	Year	Hospital

Medications

Drug Name	Strength	Frequency Taken



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Allergies to Medications

Please List:

Family Health History

Relation	Health Problem	Age At Death	Cause of Death

Social History

Tobacco	**Do you use Tobacco? Y or N?** **Have you used Tobacco in the past? Y? or N?** **How Long? Year Quit:** **How many Cigarettes/day?__ Chew __ Cigars__**
Diet	**Regular __ Vegetarian __ Vegan __ Gluten Free __ Carbohydrate __**
Exercise Level	**None __ Occasional __ Moderate __ Heavy __**
Parent’s Marital Status	**Married__ Divorced __ Unmarried __ Separated __ Widowed __**
Home Situation	**Both Parents __ Mother __ Father __ Relatives __ Adoptive Parents __** **Foster Parents __ Other _______**
Siblings (How Many)	**Brothers ___ Sisters ___**
Year in School (Pre-K-College)	_________

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