21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

6540 Park Avenue,
Allen Park, MI 48101
Ph: 313-381-2528
Fax: 313-381-3002

Dear Valued Patients,

Welcome to Grace Endocrine Services!

We are delighted to have you as part of our community. Our dedicated team is committed to providing you with compassionate, personalized care to help you achieve your health and wellness goals. We look forward to partnering with you on your journey to better health.

Grace Endocrine Services is conveniently located at two locations:

Clinton Township Location:
21510 Harrington Street, Suite 303
Clinton Township, MI 48036
Phone: (586) 741-5346
Fax: (586) 741-8886

Allen Park Location:
6540 Park Avenue
Allen Park, MI 48101
Phone: (313) 381-2528
Fax: (313) 381-3002

Please make sure to complete the attached new patient forms and return them to the clinic. You can fax the signed forms to your preferred location or bring them in person. Some forms are for your records, so please keep those for reference.

Thank you for choosing Grace Endocrine Services. We look forward to providing you with the care you need.

Warm regards,
The Grace Endocrine Services Team

New Patient Package list

Please Sign and Return the following forms to us	Keep the following consents form for your records
• Registration Form • Patient medical history form • Medication list • Acknowledgment of Receipt and consent forms	• Financial Policy • Financial Agreement • Know Your Benefits • Notice of Privacy Practices • Patient Rights & Responsibilities of Michigan • Laboratory Information & Policy • Prescription Refill Agreement • No Show / Cancellation Policy • Telehealth Consent Form

☐ 21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

☐ 6540 Park Avenue,
Allen Park, MI 48101
Ph: 313-381-2528
Fax: 313-381-3002

REGISTRATION FORM

Today's Date____/____/ _____ **Please Print** **PCP_____**

PATIENT INFORMATION				
Patient's Last Name First Middle			___ Mr. ___Miss ___ Mrs. ___Ms.	Marital Status /Race ___Single ___ Married ___Widowed ___Separated ___Divorced ___ White ___Blk ___Other
Is this your legal name ____Yes ____No	If not, what is your legal name	(Former Name)		Sex ___Male ___Female
Birth Date _____/ _____/ _____	Age	Social Security # __ __ __/ __ __/ __ __ __ __	Home Phone No. ( )	Cell Phone No. ( )
Street Address	City	State	ZIP Code	
Occupation	Employer	(Employer Phone No) ( )		

Chose clinic Because/Referred to Clinic by (Please check one) ___Dr. _____
___Insurance Plan ___ Hospital ___ Family ___ Friend ___ Close to home/ work ___Yellow Pages __ Other_____

Family Members seen here_____

INSURANCE INFORMATION **(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**			
Person Responsible for Bill Is this person a patient here? ___ Yes ___ No	Birth Date ____/ _____/ _____	Address (If different)	Home Tel: ( )
Occupation	Employer	Employer Address	Employer phone No. ( )

Is this patient covered by insurance? ___ Yes ___ No

Please indicate primary insurance **___ BCBS ____BCN ____ MEDICARE ___ MEDICAID ___ PPOM ___ DMC CARE**
____ AETNA ___ HAP ____ OMNI CARE ____ HUMANA Other_____

Subscriber's Name	Subscriber's S.S. # __ __ __/ __ __/ __ __ __ __	Birth Date _____/ ____/ _____
Group#	Policy #	Co-Payment $
Patient's Relationship to Subscriber __ Self	___Spouse ___ Child __Other	
Secondary Insurance (if Applicable)	Subscriber's S.S. # __ __ __/ __ __/ __ __ __ __	Birth Date _____/ ____/ _____
Group#	Policy #	Co-Payment $
Patient's Relationship to Subscriber __ Self	___Spouse ___ Child __Other	

IN CASE OF EMARGENCEY			
Name of Local Friend or Relative (not living at same address)	Relationship to patient	Home phone#	Work Phone #

The above information is true to the best of my knowledge. **I UNDERSTAND AND THAT I AM FINACIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.** I also authorize the insurance company to release any information required to process my claims.

X_____ X_____
PATIENT/GUARDIAN SIGNATURE **DATE**

☐ 21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

☐ 6540 Park Avenue,
Allen Park, MI 48101
Ph: 313-381-2528
Fax: 313-381-3002

PATIENT HISTORY FORM

Today's Date: _____/_____/_____

NAME: Birthdate: _____/_____/_____

_____
Last First M. I. **Age:** _____ **Sex:** ❑ **F** ❑ **M**

Reason for Visit/ Current Symptoms:

Medical History

Any Allergies to Medication/ Food/ other:

Hospitalization/ Surgeries (Where, When and reason):

Primary Care Doctor name and phone number:

Social History

Do you Smoke (Tobacco) ❑ No ❑ Yes : How much daily: ____ How long _____ ( ) Quit How long: _____

Do you use (Marijuana) ❑ No ❑ Yes: How often: ____ How long _____ ( ) Quit How long: _____

Do you drink Alcohol? ❑ No ❑ Yes : If so type? ( ) Beer ( ) wine ( )Hard Alcohol ____ Drink per week? ___
Quit How long: _____

Any other drug use: ❑ No ❑ Yes : How much daily: ____ How long ____ ( ) Quit How long: ___

Caffeine Use: ❑ No ❑ Yes: If so type? _____How much daily: ____ How long _____ ( ) Quit
How long: ___

How did you hear about us? ❑ Friends/ Family ❑ Website ❑ Physician ❑ Walk in

Patient Email

Employment Status ❑ Employed ❑ Unemployed ❑ Retired ❑ Disabled

If employed Occupation: _____ Hours per week: _____

Physician initials _____

☐ 21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

☐ 6540 Park Avenue,
Allen Park, MI 48101
Ph: 313-381-2528
Fax: 313-381-3002

PATIENT HISTORY FORM

Family History Please check all that applies

	Mother	Father	Brother	Sister	Daughter	Son	Grand Father (Maternal)	Grand Mother (Maternal)	Grand Father (paternal)	Grand Mother (paternal)	Aunt	Uncle
Arthritis												
Asthma												
Dementia												
Depression												
Diabetes Type 1												
Diabetes Type 2												
Heart disease												
High blood Pressure												
High Cholesterol												
Kidney Disease												
Obesity												
Osteoporosis												
Stroke												
Substanse Abuse												
Hypothyroidism												
Hyperthyroidism												
Breast Cancer												
Colon Cancer												
Lung Cancer												
Skin Cancer												
Stomach Cancer												
Thyroid Cancer												
Ovarian Cancer												
Uterine Cancer												
Prostate Cancer												
Testicular Cancer												

Physician initials _____

☐ 21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

☐ 6540 Park Avenue,
Allen Park, MI 48101
Ph: 313-381-2528
Fax: 313-381-3002

PATIENT HISTORY FORM

Medication Sheet

Patient Name: _____ Date _____

Allergies: _____

Pharmacy Number: _____

Date Start	Date Stop	List of Medication	Dosage	Amount	Refills		
					Date	Amount	Initials

Physician initials _____

☐ 21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

☐ 6540 Park Avenue,
Allen Park, MI 48101
Ph: 313-381-2528
Fax: 313-381-3002

*By my signature, I acknowledge that I have read, understand, agreed, and received the copy of the following signed p*atients consent *forms for my record.*

Consent forms are included:

_____ Financial Policy
_____ Financial Agreement
_____ Know your benefits
_____ Notice of Privacy Practice
_____ Patient Rights & Responsibilities of Michigan
_____ Visitor information form
_____ HIPAA Disclosure information form
_____ Laboratory information & Policy
_____ Prescription Refill agreement
_____ No show / Cancellation Policy
_____ Telehealth consent form

Patient Signature _____ **Date/ Time** _____

Witness Signature & Title _____ **Date/ Time** _____