

# NEW PATIENT REGISTRATION

If The Patient Is A Child, Fill Out The Information As It Pertains To The Child

Patient First Name \_\_\_\_\_ Last Name \_\_\_\_\_ M.I. \_\_\_\_\_  
(as on insurance card)

Male  Female Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Student Status: F/T P/T N/A

Social Security # \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Tel. # (\_\_\_\_) \_\_\_\_\_ Business Tel. # (\_\_\_\_) \_\_\_\_\_ Your Cell # \_\_\_\_\_

If you are interested in receiving discounts and promotional announcements from Advanced Specialty Care, please provide your email address and sign consent below. If you would like to opt out and anytime you can call 203-791-9661

EMAIL ADDRESS: \_\_\_\_\_

Responsible Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ DOB \_\_\_\_\_

Primary Doctor \_\_\_\_\_ Location (City) \_\_\_\_\_  
(As listed on your insurance card)

Referring Doctor \_\_\_\_\_

If your insurance plan requires an insurance authorization referral to this office, you must have this referral at the time of your visit, or full payment will be expected. It is your responsibility to ensure your authorization referral is current and on file in this office prior to seeing the physician for all visits, including follow-ups.

There are **NO** exceptions to the office referral policy.

## PRIMARY INSURANCE COMPANY INFORMATION

Information must be filled out completely, even if we copy your insurance card.

Ins. Co. Name \_\_\_\_\_ Plan \_\_\_\_\_

ID# \_\_\_\_\_ Group name or Number \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relation to patient \_\_\_\_\_

Sex:  Male  Female Date of Birth \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Phone # \_\_\_\_\_

## SECONDARY INSURANCE COMPANY INFORMATION

Ins. Co. Name \_\_\_\_\_ Plan \_\_\_\_\_

ID# \_\_\_\_\_ Group name or Number \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relation to patient \_\_\_\_\_

Sex:  Male  Female Date of Birth \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Phone # \_\_\_\_\_

If this office does not have a contract with your insurance company, payment must be made at the time of visit unless prior arrangements have been made with the office manager. It is your responsibility to follow up on any outstanding claims sent to your insurance company, and to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company. If services rendered are considered non-covered by your insurance company you will be responsible for payment in full.

This signature on file indicates that I have read and agree to the terms above. It is also an authorization to release my medical records, which may include photographs, to the physician above and those physicians who may be involved in my care now and in the future, as well as information necessary to process my claims. I hereby authorize payment directly to the person named on the insurance benefits otherwise payable to me. I authorize the care and treatment provided to me under the general or specific directions of my physician or physician assistant.

\_\_\_\_\_  
Patient Signature (If Minor, Parent/Guardian Signature)

\_\_\_\_\_  
Parent/Guardian Date of Birth

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

<b>MEDICAL HISTORY:</b> N/A <input type="checkbox"/>	<b>SURGICAL HISTORY:</b> N/A <input type="checkbox"/>	<b>REVIEW OF SYSTEMS:</b> N/A <input type="checkbox"/>
<b>Check all that apply</b>	<b>List all procedures patient has had</b>	<b>Check any you currently experience</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No ANEMIA <input type="checkbox"/> Yes <input type="checkbox"/> No ANGINA <input type="checkbox"/> Yes <input type="checkbox"/> No ANXIETY <input type="checkbox"/> Yes <input type="checkbox"/> No ASTHMA <input type="checkbox"/> Yes <input type="checkbox"/> No AUTOIMMUNE DISORDER <input type="checkbox"/> Yes <input type="checkbox"/> No BLEEDING DISORDER <input type="checkbox"/> Yes <input type="checkbox"/> No BLOOD CLOTS <input type="checkbox"/> Yes <input type="checkbox"/> No CANCER Type: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No CURRENTLY PREGNANT <input type="checkbox"/> Yes <input type="checkbox"/> No DEPRESSION <input type="checkbox"/> Yes <input type="checkbox"/> No DIABETES <input type="checkbox"/> Yes <input type="checkbox"/> No EMPHYSEMA <input type="checkbox"/> Yes <input type="checkbox"/> No HEART ATTACK <input type="checkbox"/> Yes <input type="checkbox"/> No HIGH BLOOD PRESSURE <input type="checkbox"/> Yes <input type="checkbox"/> No HIGH CHOLESTEROL <input type="checkbox"/> Yes <input type="checkbox"/> No KIDNEY DISORDER <input type="checkbox"/> Yes <input type="checkbox"/> No LIVER DISEASE <input type="checkbox"/> Yes <input type="checkbox"/> No PACEMAKER <input type="checkbox"/> Yes <input type="checkbox"/> No PSYCHIATRIC PROBLEMS <input type="checkbox"/> Yes <input type="checkbox"/> No REFLEX <input type="checkbox"/> Yes <input type="checkbox"/> No SEIZURE DISORDER <input type="checkbox"/> Yes <input type="checkbox"/> No SLEEP APNEA <input type="checkbox"/> Yes <input type="checkbox"/> No SLEEP APNEA ON CPAP <input type="checkbox"/> Yes <input type="checkbox"/> No STROKE <input type="checkbox"/> Yes <input type="checkbox"/> No THYROID DISEASE <input type="checkbox"/> Yes <input type="checkbox"/> No TRAUMA <input type="checkbox"/> Yes <input type="checkbox"/> No ULCERS Type: _____ <input type="checkbox"/> OTHER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No ADENOIDECTOMY <input type="checkbox"/> Yes <input type="checkbox"/> No ANGIOPLASTY <input type="checkbox"/> CORONARY BYPASS <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No APPENDECTOMY Open surgery or laparoscopic? _____ Date? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No BACK SURGERY <input type="checkbox"/> Yes <input type="checkbox"/> No BREAST SURGERY/PROCEDURE Type? _____ Date? _____ <input type="checkbox"/> MASTECTOMY side: R / L Radiation? Y / N Date _____ Physician _____ <input type="checkbox"/> LUMPECTOMY side: R / L Date _____ Physician _____ <input type="checkbox"/> REDUCTION Date _____ Physician _____ <input type="checkbox"/> AUGMENTATION (implants) Date _____ Physician _____ <input type="checkbox"/> MASTOPEXY (lift) Date _____ Physician _____ <input type="checkbox"/> OTHER Date _____ Physician _____ Date Last Mammogram _____ <input type="checkbox"/> Yes <input type="checkbox"/> No CANCER SURGERY Type: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No COSMETIC NOSE SURGERY <input type="checkbox"/> Yes <input type="checkbox"/> No EAR SURGERY <input type="checkbox"/> Yes <input type="checkbox"/> No EAR TUBES <input type="checkbox"/> Yes <input type="checkbox"/> No GALL BLADDER <input type="checkbox"/> Yes <input type="checkbox"/> No HERNIA Type: _____ Open surgery or laparoscopic? _____ Date? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No HYSTERECTOMY <input type="checkbox"/> Yes <input type="checkbox"/> No JOINT SURGERY <input type="checkbox"/> Yes <input type="checkbox"/> No NASAL SEPTUM SURGERY <input type="checkbox"/> Yes <input type="checkbox"/> No PARATHYROIDECTOMY <input type="checkbox"/> Yes <input type="checkbox"/> No SINUS SURGERY <input type="checkbox"/> Yes <input type="checkbox"/> No THYROIDECTOMY <input type="checkbox"/> Yes <input type="checkbox"/> No TONSILLECTOMY <input type="checkbox"/> Yes <input type="checkbox"/> No COSMETIC SURGERY/PROCEDURE Type Date Physician _____ _____ _____ <input type="checkbox"/> Yes <input type="checkbox"/> No ABDOMINAL SURGERY/PROCEDURE Type Date Physician _____ _____ _____ <input type="checkbox"/> OTHER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No FEVER <input type="checkbox"/> Yes <input type="checkbox"/> No FATIGUE <input type="checkbox"/> Yes <input type="checkbox"/> No NIGHT SWEATS <input type="checkbox"/> Yes <input type="checkbox"/> No VISUAL LOSS <input type="checkbox"/> Yes <input type="checkbox"/> No NOISE IN EARS <input type="checkbox"/> Yes <input type="checkbox"/> No HEADACHES <input type="checkbox"/> Yes <input type="checkbox"/> No SHORTNESS OF BREATH <input type="checkbox"/> Yes <input type="checkbox"/> No COUGH <input type="checkbox"/> Yes <input type="checkbox"/> No CHEST PAIN <input type="checkbox"/> Yes <input type="checkbox"/> No PALPITATION <input type="checkbox"/> Yes <input type="checkbox"/> No LEG CRAMPS <input type="checkbox"/> Yes <input type="checkbox"/> No VOMITING <input type="checkbox"/> Yes <input type="checkbox"/> No DIARRHEA <input type="checkbox"/> Yes <input type="checkbox"/> No CONSTIPATION <input type="checkbox"/> Yes <input type="checkbox"/> No BLOODY URINE <input type="checkbox"/> Yes <input type="checkbox"/> No DIFFICULTLY URINATING <input type="checkbox"/> Yes <input type="checkbox"/> No GENITAL DISCHARGE <input type="checkbox"/> Yes <input type="checkbox"/> No BREAST DISCHARGE/ MASS <input type="checkbox"/> Yes <input type="checkbox"/> No COLD <input type="checkbox"/> HEAT INTOLERANCE <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No DIZZINESS <input type="checkbox"/> Yes <input type="checkbox"/> No EMOTIONAL DISTURBANCE <input type="checkbox"/> Yes <input type="checkbox"/> No RASH <input type="checkbox"/> ITCHING <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No BACK <input type="checkbox"/> JOINT PAIN <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No EASY BRUISING <input type="checkbox"/> BLEEDING <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No ALLERGIES: Inhalent _____ / Food _____ / Environmental _____

**ALLERGIES TO MEDICATIONS:**  
Please List. What reaction occurs?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
LATEX ALLERGY?  YES  NO

**ILLICIT DRUGS:**  
 YES  NO  FORMER  
PLEASE LIST \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY:** N/A   
**Any close relatives with the following?**

Yes  No ALLERGIES  
 Yes  No ALZHEIMERS  
 Yes  No ANESTHESIA REACTIONS  
 Yes  No ASTHMA  
 Yes  No ALCOHOLISM  
 Yes  No BLEEDING DISORDER  
 Yes  No BLOOD DISEASE  
 Yes  No BREAST CANCER  
 Yes  No CANCER (please circle below)  
Type: Ovarian / Colon / Thyroid / Breast  
Lung / Other: \_\_\_\_\_  
 Yes  No DIABETES  
 Yes  No HEARING DEFICIENCY  
 Yes  No HEART DISEASE  
 Yes  No HIGH BLOOD PRESSURE  
 Yes  No HIGH CHOLESTEROL  
 Yes  No KIDNEY DISEASE  
 Yes  No MENTAL ILLNESS  
 Yes  No MIGRAINES  
 Yes  No SEIZURE DISORDER  
 Yes  No STROKE  
 Yes  No THYROID DISORDER

Yes  No LYMPH NODE DISSECTION  
Left or Right? \_\_\_\_\_  
 Yes  No LYMPH NODE BIOPSY  
Left or Right? \_\_\_\_\_  
Date Last Ultrasound \_\_\_\_\_  
Date Last MRI \_\_\_\_\_

**PERTAINING TO YOUR VISIT TODAY, HAVE YOU HAD ANY RECENT TESTING OR IMAGING?**  
 Yes  No CT SCAN  
 Yes  No MRI  
 Yes  No ULTRASOUND  
 Yes  No X-RAY  
 Yes  No SLEEP STUDY  
 Yes  No BARIUM SWALLOW  
 Yes  No BLOOD WORK  
IF YES, DATE \_\_\_\_\_  
FACILITY: \_\_\_\_\_

**SOCIAL HISTORY:** FOR CHILD: N/A   
**TOBACCO**  
CURRENTLY SMOKE?  YES  NO  
 SMOKED IN PAST HOW MUCH? \_\_\_\_\_  
**ALCOHOL**  
 DO NOT DRINK  DRINK SOCIALLY  DRINK DAILY  
**CAFFEINE**  
 NONE  \_\_\_\_\_ CUPS

**IF PATIENT IS A CHILD:**  
CHILD LIVES WITH  
 MOTHER  FATHER  OTHER  
DAY CARE OUT OF HOUSE?  YES  NO  
HOUSEHOLD SMOKE EXPOSURE?  YES  NO

**MEDICATIONS CURRENTLY TAKING:**  
List all prescription, non-prescription medications and herbal supplements./Dosage  
 NONE / \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**COMMON HERBAL MEDICATIONS:**

<input type="checkbox"/> Aloe	<input type="checkbox"/> Ginseng
<input type="checkbox"/> Arnica	<input type="checkbox"/> Goldenseal
<input type="checkbox"/> Bilberry	<input type="checkbox"/> Hawthorne
<input type="checkbox"/> Bromelain	<input type="checkbox"/> Kava Kava
<input type="checkbox"/> Dong Quai	<input type="checkbox"/> Licorice
<input type="checkbox"/> Echinacea	<input type="checkbox"/> Parsley Seed
<input type="checkbox"/> Fatty Acids	<input type="checkbox"/> Saw Palmetto
<input type="checkbox"/> Fever Few	<input type="checkbox"/> St. John's Wart
<input type="checkbox"/> Fish Oil Caps	<input type="checkbox"/> Valerian
<input type="checkbox"/> Flax Seed Oil	<input type="checkbox"/> Vitamin E
<input type="checkbox"/> Garlic	<input type="checkbox"/> Yohimbe
<input type="checkbox"/> Gingko	

**PHARMACY FOR REFILLS:** \*PLEASE FILL IN  
Name: \_\_\_\_\_  
Location: \_\_\_\_\_  
\*Referring MD \_\_\_\_\_  
\*PCP \_\_\_\_\_

**PATIENT'S NAME (PLEASE PRINT)** \_\_\_\_\_  
**PATIENT'S date of birth** \_\_\_\_\_  
**DATE:** \_\_\_\_\_  
**PHYSICIAN REVIEWED/DATE:** \_\_\_\_\_

