

# 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 email address and sign consent below. To opt out at anytime, call 203-791-9661

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

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

Parent/ Guardian Phone \_\_\_\_\_

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

Emergency Contact Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Home Tel #: \_\_\_\_\_ Cell # \_\_\_\_\_

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 and 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.

\*HSA POLICY-If you have a health savings account insurance plan, and your deductible has not been met, we request payment at time of service, a payment plan can be set up with our billing department. Your office visit can range anywhere from \$150-\$260, to additional testing ranging from \$200-\$800.

## PRIMARY INSURANCE COMPANY INFORMATION

Information must be filled in 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 # \_\_\_\_\_

\_\_\_\_\_  
Date

<b>PATIENT'S NAME (PLEASE PRINT)</b> _____ <b>PATIENT'S date of birth</b> _____ <b>DATE:</b> _____ <b>PHYSICIAN REVIEWED/DATE:</b> _____		<b>PHARMACY FOR REFILLS: *PLEASE FILL IN</b> <b>Name:</b> _____ <b>Location:</b> _____ <b>*Referring MD</b> _____ <b>*DCP</b> _____																		
<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>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 REFLUX <input type="checkbox"/> Yes <input type="checkbox"/> No SEIZURE DISORDER <input type="checkbox"/> Yes <input type="checkbox"/> No SLEEP APNEA If yes facility sleep study done _____ <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 <table style="width:100%; border: none;"> <tr> <td style="width:33%;">Type</td> <td style="width:33%;">Date</td> <td style="width:33%;">Physician</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table> <input type="checkbox"/> Yes <input type="checkbox"/> No ABDOMINAL SURGERY/ PROCEDURE <table style="width:100%; border: none;"> <tr> <td style="width:33%;">Type</td> <td style="width:33%;">Date</td> <td style="width:33%;">Physician</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table> <input type="checkbox"/> OTHER _____ <input type="checkbox"/> Yes <input type="checkbox"/> No LYMPH NODE DISSECTION Left or Right? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No LYMPH NODE BIOPSY Left or Right? _____ Date Last Ultrasound _____ Date Last MRI _____	Type	Date	Physician	_____	_____	_____	_____	_____	_____	Type	Date	Physician	_____	_____	_____	_____	_____	_____	<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 COID <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: Inhaled _____ / Food _____ / Environmental _____
Type	Date	Physician																		
_____	_____	_____																		
_____	_____	_____																		
Type	Date	Physician																		
_____	_____	_____																		
_____	_____	_____																		
<b>ALLERGIES TO MEDICATIONS:</b> Please List. What reaction occurs? _____ _____ _____ _____ <b>ATEX ALLERGY?</b> ___ YES ___ NO	<b>SOCIAL HISTORY:</b> FOR CHILD: N/A <input type="checkbox"/> <b>TOBACCO</b> CURRENTLY SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> SMOKED IN PAST HOW MUCH? _____ <b>ALCOHOL</b> <input type="checkbox"/> <b>CAFFEINE</b> <input type="checkbox"/> NONE <input type="checkbox"/> _____ CUPS	<b>IF PATIENT IS A CHILD:</b> CHILD LIVES WITH <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> OTHER <b>DAY CARE OUT OF HOUSE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO																		
<b>ILICIT DRUGS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> FORMER PLEASE LIST _____ _____	<input type="checkbox"/> OTHER _____	<b>MEDICATIONS CURRENTLY TAKING:</b> List all prescription, non-prescription medications and herbal supplements./Dosage <input type="checkbox"/> NONE / _____ _____ _____																		
<b>FAMILY HISTORY:</b> N/A <input type="checkbox"/> <b>My closest relatives with the following?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No ALLERGIES <input type="checkbox"/> Yes <input type="checkbox"/> No ALZHEIMERS <input type="checkbox"/> Yes <input type="checkbox"/> No ANESTHESIA REACTIONS <input type="checkbox"/> Yes <input type="checkbox"/> No ASTHMA <input type="checkbox"/> Yes <input type="checkbox"/> No ALCOHOLISM <input type="checkbox"/> Yes <input type="checkbox"/> No BLEEDING DISORDER <input type="checkbox"/> Yes <input type="checkbox"/> No BLOOD DISEASE <input type="checkbox"/> Yes <input type="checkbox"/> No BREAST CANCER <input type="checkbox"/> Yes <input type="checkbox"/> No CANCER (please circle below) type: Ovarian / Colon / Thyroid / Breast ung / Other: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No DIABETES <input type="checkbox"/> Yes <input type="checkbox"/> No HEARING DEFICIENCY <input type="checkbox"/> Yes <input type="checkbox"/> No HEART DISEASE <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 DISEASE <input type="checkbox"/> Yes <input type="checkbox"/> No MENTAL ILLNESS <input type="checkbox"/> Yes <input type="checkbox"/> No MIGRAINES <input type="checkbox"/> Yes <input type="checkbox"/> No SEIZURE DISORDER <input type="checkbox"/> Yes <input type="checkbox"/> No STROKE <input type="checkbox"/> Yes <input type="checkbox"/> No THYROID DISORDER	<b>PERTAINING TO YOUR VISIT TODAY, HAVE YOU HAD ANY RECENT TESTING OR IMAGING?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No CT SCAN <input type="checkbox"/> Yes <input type="checkbox"/> No MRI <input type="checkbox"/> Yes <input type="checkbox"/> No ULTRASOUND <input type="checkbox"/> Yes <input type="checkbox"/> No X-RAY <input type="checkbox"/> Yes <input type="checkbox"/> No SLEEP STUDY <input type="checkbox"/> Yes <input type="checkbox"/> No BARIUM SWALLOW <input type="checkbox"/> Yes <input type="checkbox"/> No BLOOD WORK IF YES, DATE _____ FACILITY: _____	<b>COMMON HERBAL MEDICATIONS:</b> <table style="width:100%; border: none;"> <tr> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> Aloe  <input type="checkbox"/> Arnica  <input type="checkbox"/> Bilberry  <input type="checkbox"/> Bromelain  <input type="checkbox"/> Dong Quai  <input type="checkbox"/> Echinacea  <input type="checkbox"/> Fatty Acids  <input type="checkbox"/> Fever Few  <input type="checkbox"/> Fish Oil Caps  <input type="checkbox"/> Flax Seed Oil  <input type="checkbox"/> Garlic  <input type="checkbox"/> Gingkgo               </td> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> Ginseng  <input type="checkbox"/> Goldenseal  <input type="checkbox"/> Hawthorne  <input type="checkbox"/> Kava Kava  <input type="checkbox"/> Licorice  <input type="checkbox"/> Parsley Seed  <input type="checkbox"/> Saw Palmetto  <input type="checkbox"/> St. John's Wart  <input type="checkbox"/> Valerian  <input type="checkbox"/> Vitamin E  <input type="checkbox"/> Yohimbe               </td> </tr> </table>	<input type="checkbox"/> Aloe <input type="checkbox"/> Arnica <input type="checkbox"/> Bilberry <input type="checkbox"/> Bromelain <input type="checkbox"/> Dong Quai <input type="checkbox"/> Echinacea <input type="checkbox"/> Fatty Acids <input type="checkbox"/> Fever Few <input type="checkbox"/> Fish Oil Caps <input type="checkbox"/> Flax Seed Oil <input type="checkbox"/> Garlic <input type="checkbox"/> Gingkgo	<input type="checkbox"/> Ginseng <input type="checkbox"/> Goldenseal <input type="checkbox"/> Hawthorne <input type="checkbox"/> Kava Kava <input type="checkbox"/> Licorice <input type="checkbox"/> Parsley Seed <input type="checkbox"/> Saw Palmetto <input type="checkbox"/> St. John's Wart <input type="checkbox"/> Valerian <input type="checkbox"/> Vitamin E <input type="checkbox"/> Yohimbe																
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**ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF:  
Notice of Privacy Practices  
Informed Consent  
Practice Financial Policies  
Notice Regarding Ridgefield Surgical Center, LLC**

**ADVANCED SPECIALTY CARE**

107 Newtown Road, Danbury, CT 06810  
131 Kent Road New Milford, CT 06776

901 Ethan Allen Highway, Ridgefield, CT 06877  
22 Old Waterbury Road, Southbury, CT 06488

Privacy Officer: Jennifer Retter, Business Manager (203) 830-4700 ext. 265

I hereby acknowledge that I was given the opportunity to review this medical practice's **Notice Of Privacy Practices (HIPAA)**, and that I have the right to ask for a paper copy of the Notice to take with me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

I authorize the person(s) listed below to discuss my medical information:

Name	Relationship to Patient
Name	Relationship to Patient

Please note that ASC employees may discuss payment issues with family members or other personal representatives, including the subscriber of my insurance plan, unless I request special privacy protections. My signature on this form authorizes such financial discussion.

Under certain circumstances, this office may need to request lab reports, radiology reports, or other diagnostic test results from outside facilities. At times these facilities may require an authorization to release such records. My signature authorizes the release of any diagnostic test results that we may require in order to provide treatment.

I understand that no procedure provided by this facility is completely without risk and I authorize the care and treatment provided to me under the general or specific directions of my physician or my physician assistant.

**If this office does not have a contract with my insurance company, payment must be made at the time of visit** unless prior arrangements have been made with the office manager. For patients with coverage that we participate with we will file your insurance claims to your primary carrier for all services and procedures we provide. It is your responsibility to secure all referrals and authorizations required by your health plan and to be aware of its coverage and benefits. All charges are your responsibility from the date the services are rendered. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. If payment is not received in a timely manner, my account will be turned over to a collection agency. I agree to notify the office of Advanced Specialty Care of any changes to my insurance coverage so that filing my claim is expedited.

I hereby acknowledge that I have been given an opportunity to review the posted notice to patients regarding physician ownership of Ridgefield Surgical Center, LLC.

\_\_\_\_\_  
Signature (Parent or Guardian if Patient a Minor)

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

\_\_\_\_\_  
Patients Name (if Minor)

\_\_\_\_\_  
Relationship To Patient

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient's date of birth