

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 _____

ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF:

Notice of Privacy Practices

Informed Consent

Practice Financial Policies

ADVANCED SPECIALTY CARE

107 Newtown Road, Danbury, CT 06810
146 Danbury 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. **If you do not speak English please list the name and phone number of who we can call to discuss your medical information with.**

Name & phone number

Relationship to Patient

Name & phone number

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.

Signature (Parent or Guardian if Patient a Minor)

Relationship To Patient

Please Print Name

_____/_____/_____
Date

Patients Name (if Minor)

_____/_____/_____
Patient's date of birth

Dizziness Questionnaire

Patient's First Name: _____ Last Name: _____

Patient's Date of Birth: _____

PLEASE ANSWER ALL THE QUESTIONS:

When you are "dizzy" do you experience any of the following sensations? Please read the entire list first. Check YES or NO to describe your feelings most accurately.

	YES	NO
1. Lightheadedness or swimming sensation in head?		
2. Blacking out or loss of consciousness?		
3. Do you have a tendency to fall? (If NO skip to question 4)		
To the right?		
To the left?		
Forwards?		
Backwards?		
4. Objects spinning or turning around you?		
5. Sensation that you are turning or spinning inside, with outside objects remaining stationary?		
6. Loss of balance when walking? (If NO skip to next questions)		
Veering to the right?		
Veering to the left?		
7. Nausea or Vomiting?		
8. Pressure in the head?		

Dizziness Questionnaire pg 2

Please check YES or No and fill in the blank spaces.

	YES	NO
1. My dizziness is?		
Constant?		
In attacks?		
2. When did the dizziness first occur?		
3. If in attacks:		
How often do they occur?		
How long do they last?		
When was the last attack?		
4. Do you have any warning the attack is about to start?		
5. Do they occur at any particular time of day or night?		
6. Are you completely free of dizziness between attacks?		
7. Does change of position make you dizzy?		
8. Do you have trouble walking in the dark?		
9. When you are dizzy, must you support yourself with standing?		
10. Do you know of any possible cause of your dizziness?		
If so, what?		
11. Do you know anything that will...		
Stop your dizziness or make it better?		
If so, what?		
Make your dizziness worse?		
If so, what?		
12. Check yes for any of the following that may precipitate an attack?		
Fatigue		
Exertion		
Hunger		
Menstrual Period		
Stress		
Emotional Upset		
13. Were you exposed to any irritating fumes, paints, etc. at the onset of the dizziness?		
14. Have you ever injured your head?		
If yes, were you unconscious?		

If you began taking any medications when the dizziness began, please list.

Dizziness Questionnaire pg 3

Do you have any of the following symptoms? (Check YES or NO and Check which ear.)

	YES	NO	Both Ears	Right Only	Left Only
1. Difficulty in hearing?					
If YES, which ear?					
2. Noise in your ears?					
If YES, which ear?					
3. Describe the noise:					
4. Does the noise change with dizziness?					
If so, how?					
5. Fullness or stuffiness in your ears?					
If YES, which ear?					
6. Pain in your ears?					
If YES, which ear?					
7. Discharge from your ears?					
If YES, which ear?					

Have you experienced any of the following symptoms? (Please check YES or NO and if Yes, check if constant or if in episodes)

	YES	NO	CONSTANT	EPISODES
1. Double vision, blurred vision or blindness?				
If YES, which?				
2. Numbness of face?				
If YES, which?				
3. Numbness of arms or legs?				
If YES, which?				
4. Weakness in arms or legs?				
If YES, which?				
5. Clumsiness of arms or legs?				
If YES, which?				
6. Confusion or loss of consciousness?				
If YES, which?				
7. Difficulty swallowing?				
If YES, which?				
8. Difficulty with speech?				
If YES, which?				
9. Pain in the neck or shoulder?				
If YES, which?				

Please feel free to add any additional information relating to this problem. Thank you.