

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 party named of 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

**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:

<hr/>	<hr/>
Name	Relationship to Patient
<hr/>	<hr/>
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. It is my responsibility to follow up on any outstanding claims sent to my insurance company, and to pay any deductible amount, co-insurance, or any other balance not paid by my insurance company. If services rendered are considered non-covered by my insurance company, I will be responsible for payment in full. My 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 those physicians who may be involved in my care, as well as information necessary to process my claims. I hereby authorize payment directly to the physician named of the insurance benefits otherwise payable to me.

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

<hr/>	<hr/>
Signature (Parent or Guardian if Patient a Minor)	Relationship To Patient
<hr/>	<hr/>
Please Print Name	Date
<hr/>	<hr/>
Patients Name (if Minor)	Patient's date of birth

MEDICAL HISTORY: N/A <input type="checkbox"/>	SURGICAL HISTORY: N/A <input type="checkbox"/>	REVIEW OF SYSTEMS: N/A <input type="checkbox"/>																		
<i>Check all that apply</i>	<i>List all procedures patient has had</i>	<i>Check any you currently experience</i>																		
<input type="radio"/> Yes <input type="radio"/> No ANEMIA <input type="radio"/> Yes <input type="radio"/> No ANGINA <input type="radio"/> Yes <input type="radio"/> No ANXIETY <input type="radio"/> Yes <input type="radio"/> No ASTHMA <input type="radio"/> Yes <input type="radio"/> No AUTOIMMUNE DISORDER <input type="radio"/> Yes <input type="radio"/> No BLEEDING DISORDER <input type="radio"/> Yes <input type="radio"/> No BLOOD CLOTS <input type="radio"/> Yes <input type="radio"/> No CANCER Type: _____ <input type="radio"/> Yes <input type="radio"/> No CURRENTLY PREGNANT <input type="radio"/> Yes <input type="radio"/> No DEPRESSION <input type="radio"/> Yes <input type="radio"/> No DIABETES <input type="radio"/> Yes <input type="radio"/> No EMPHYSEMA <input type="radio"/> Yes <input type="radio"/> No HEART ATTACK <input type="radio"/> Yes <input type="radio"/> No HIGH BLOOD PRESSURE <input type="radio"/> Yes <input type="radio"/> No HIGH CHOLESTEROL <input type="radio"/> Yes <input type="radio"/> No KIDNEY DISORDER <input type="radio"/> Yes <input type="radio"/> No LIVER DISEASE <input type="radio"/> Yes <input type="radio"/> No PACEMAKER <input type="radio"/> Yes <input type="radio"/> No PSYCHIATRIC PROBLEMS <input type="radio"/> Yes <input type="radio"/> No REFLUX <input type="radio"/> Yes <input type="radio"/> No SEIZURE DISORDER <input type="radio"/> Yes <input type="radio"/> No SLEEP APNEA If yes facility sleep study done _____ <input type="radio"/> Yes <input type="radio"/> No SLEEP APNEA ON CPAP <input type="radio"/> Yes <input type="radio"/> No STROKE <input type="radio"/> Yes <input type="radio"/> No THYROID DISEASE <input type="radio"/> Yes <input type="radio"/> No TRAUMA <input type="radio"/> Yes <input type="radio"/> No ULCERS Type: _____ <input type="radio"/> OTHER _____	<input type="radio"/> Yes <input type="radio"/> No ADENOIDECTOMY <input type="radio"/> Yes <input type="radio"/> No ANGIOPLASTY <input type="checkbox"/> CORONARY BYPASS <input type="checkbox"/> <input type="radio"/> Yes <input type="radio"/> No APPENDECTOMY Open surgery or laparoscopic? _____ Date? _____ <input type="radio"/> Yes <input type="radio"/> No BACK SURGERY <input type="radio"/> Yes <input type="radio"/> 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="radio"/> Yes <input type="radio"/> No CANCER SURGERY Type: _____ <input type="radio"/> Yes <input type="radio"/> No COSMETIC NOSE SURGERY <input type="radio"/> Yes <input type="radio"/> No EAR SURGERY <input type="radio"/> Yes <input type="radio"/> No EAR TUBES <input type="radio"/> Yes <input type="radio"/> No GALL BLADDER <input type="radio"/> Yes <input type="radio"/> No HERNIA Type: _____ Open surgery or laparoscopic? _____ Date? _____ <input type="radio"/> Yes <input type="radio"/> No HYSTERECTOMY <input type="radio"/> Yes <input type="radio"/> No JOINT SURGERY <input type="radio"/> Yes <input type="radio"/> No NASAL SEPTUM SURGERY <input type="radio"/> Yes <input type="radio"/> No PARATHYROIDECTOMY <input type="radio"/> Yes <input type="radio"/> No SINUS SURGERY <input type="radio"/> Yes <input type="radio"/> No THYROIDECTOMY <input type="radio"/> Yes <input type="radio"/> No TONSILLECTOMY <input type="radio"/> Yes <input type="radio"/> No COSMETIC SURGERY/ PROCEDURE <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Type</td> <td style="text-align: center;">Date</td> <td style="text-align: center;">Physician</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table> <input type="radio"/> Yes <input type="radio"/> No ABDOMINAL SURGERY/ PROCEDURE <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Type</td> <td style="text-align: center;">Date</td> <td style="text-align: center;">Physician</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table> <input type="radio"/> OTHER _____ <input type="radio"/> Yes <input type="radio"/> No LYMPH NODE DISSECTION Left or Right? _____ <input type="radio"/> Yes <input type="radio"/> No LYMPH NODE BIOPSY Left or Right? _____ Date Last Ultrasound _____ Date Last MRI _____	Type	Date	Physician	_____	_____	_____	_____	_____	_____	Type	Date	Physician	_____	_____	_____	_____	_____	_____	<input type="radio"/> Yes <input type="radio"/> No FEVER <input type="radio"/> Yes <input type="radio"/> No FATIGUE <input type="radio"/> Yes <input type="radio"/> No NIGHT SWEATS <input type="radio"/> Yes <input type="radio"/> No VISUAL LOSS <input type="radio"/> Yes <input type="radio"/> No NOISE IN EARS <input type="radio"/> Yes <input type="radio"/> No HEADACHES <input type="radio"/> Yes <input type="radio"/> No SHORTNESS OF BREATH <input type="radio"/> Yes <input type="radio"/> No COUGH <input type="radio"/> Yes <input type="radio"/> No CHEST PAIN <input type="radio"/> Yes <input type="radio"/> No PALPITATION <input type="radio"/> Yes <input type="radio"/> No LEG CRAMPS <input type="radio"/> Yes <input type="radio"/> No VOMITING <input type="radio"/> Yes <input type="radio"/> No DIARRHEA <input type="radio"/> Yes <input type="radio"/> No CONSTIPATION <input type="radio"/> Yes <input type="radio"/> No BLOODY URINE <input type="radio"/> Yes <input type="radio"/> No DIFFICULTLY URINATING <input type="radio"/> Yes <input type="radio"/> No GENITAL DISCHARGE <input type="radio"/> Yes <input type="radio"/> No BREAST DISCHARGE/ MASS <input type="radio"/> Yes <input type="radio"/> No COLD <input type="checkbox"/> HEAT INTOLERANCE <input type="checkbox"/> <input type="radio"/> Yes <input type="radio"/> No DIZZINESS <input type="radio"/> Yes <input type="radio"/> No EMOTIONAL DISTURBANCE <input type="radio"/> Yes <input type="radio"/> No RASH <input type="checkbox"/> ITCHING <input type="checkbox"/> <input type="radio"/> Yes <input type="radio"/> No BACK <input type="checkbox"/> JOINT PAIN <input type="checkbox"/> <input type="radio"/> Yes <input type="radio"/> No EASY BRUISING <input type="checkbox"/> BLEEDING <input type="checkbox"/> <input type="radio"/> Yes <input type="radio"/> No ALLERGIES: Inhalent _____ / Food _____ / Environmental _____
Type	Date	Physician																		
_____	_____	_____																		
_____	_____	_____																		
Type	Date	Physician																		
_____	_____	_____																		
_____	_____	_____																		

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

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

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"/> Amica	<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"/> Gingkgo	

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

Dizziness Questionnaire

Patient's First Name: _____ Last Name: _____

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.