

PATIENT REGISTRATION

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

Patient First Name (As on insurance card) Last Name M.I.

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 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.

*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

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

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

MEDICAL HISTORY: N/A
 Check all that apply:
 ANEMIA
 ANGINA
 ANXIETY
 ASTHMA
 AUTOIMMUNE DISORDER
 BLEEDING DISORDER
 BLOOD CLOTS
 CANCER Type: _____
 CURRENTLY PREGNANT
 DEPRESSION
 DIABETES
 EMPHYSEMA
 HEART ATTACK
 HIGH BLOOD PRESSURE
 HIGH CHOLESTEROL
 KIDNEY DISORDER
 LIVER DISEASE
 PACEMAKER
 PSYCHIATRIC PROBLEMS
 REFLUX
 SEIZURE DISORDER
 SLEEP APNEA
 If yes facility sleep study done _____
 SLEEP APNEA ON CPAP
 STROKE
 THYROID DISEASE
 TRAUMA
 ULCERS
 Type: _____
 OTHER _____

SURGICAL HISTORY: N/A
 Check all procedures patient has had:
 ADENOIDECTOMY
 ANGIOPLASTY CORONARY BYPASS
 APPENDECTOMY
 Open surgery or laparoscopic? _____ Date? _____
 BACK SURGERY
 BREAST SURGERY/PROCEDURE
 Type? _____ Date? _____
 MASTECTOMY side: R / L Radiation? Y / N
 Date _____ Physician _____
 LUMPECTOMY side: R / L
 Date _____ Physician _____
 REDUCTION
 Date _____ Physician _____
 AUGMENTATION (implants)
 Date _____ Physician _____
 MASTOPEXY (lift)
 Date _____ Physician _____
 OTHER
 Date _____ Physician _____
 Date Last Mammogram _____
 CANCER SURGERY Type: _____
 COSMETIC NOSE SURGERY
 EAR SURGERY
 EAR TUBES
 GALL BLADDER
 HERNIA Type: _____
 Open surgery or laparoscopic? _____ Date? _____
 HYSTERECTOMY
 JOINT SURGERY
 NASAL SEPTUM SURGERY
 PARATHYROIDECTOMY
 SINUS SURGERY
 THYROIDECTOMY
 TONSILLECTOMY
 COSMETIC SURGERY/ PROCEDURE
 Type Date Physician

 ABDOMINAL SURGERY/ PROCEDURE
 Type Date Physician

 OTHER _____

REVIEW OF SYSTEMS: N/A
 Check any you currently experience:
 FEVER
 FATIGUE
 NIGHT SWEATS
 VISUAL LOSS
 NOISE IN EARS
 HEADACHES
 SHORTNESS OF BREATH
 COUGH
 CHEST PAIN
 PALPITATION
 LEG CRAMPS
 VOMITING
 DIARRHEA
 CONSTIPATION
 BLOODY URINE
 DIFFICULTLY URINATING
 GENITAL DISCHARGE
 BREAST DISCHARGE/ MASS
 COLD HEAT INTOLERANCE
 DIZZINESS
 EMOTIONAL DISTURBANCE
 RASH ITCHING
 BACK JOINT PAIN
 EASY BRUIISING BLEEDING
 ALLERGIES:
 Inhalent _____ / Food _____ / Environmental _____

ALLERGIES TO MEDICATIONS:
 Please List, What reaction occurs?

 LATEX ALLERGY? YES NO

SOCIAL HISTORY: FOR CHILD: N/A
TOBACCO
 CURRENTLY SMOKE? YES NO
 SMOKED IN PAST HOW MUCH? _____
ALCOHOL

CAFFEINE
 NONE _____ CUPS

ILLICIT DRUGS:
 YES NO FORMER
 PLEASE LIST _____

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

FAMILY HISTORY: N/A
 Any close relatives with the following?
 ALLERGIES
 ALZHEIMERS
 ANESTHESIA REACTIONS
 ASTHMA
 ALCOHOLISM
 BLEEDING DISORDER
 BLOOD DISEASE
 BREAST CANCER
 CANCER (please circle below)
 Type: Ovarian / Colon / Thyroid / Breast
 Lung / Other: _____
 DIABETES
 HEARING DEFICIENCY
 HEART DISEASE
 HIGH BLOOD PRESSURE
 HIGH CHOLESTEROL
 KIDNEY DISEASE
 MENTAL ILLNESS
 MIGRAINES
 SEIZURE DISORDER
 STROKE
 THYROID DISORDER

LYMPH NODE DISSECTION
 Left or Right? _____
 LYMPH NODE BIOPSY
 Left or Right? _____
 Date Last Ultrasound _____
 Date Last MRI _____

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

PERTAINING TO YOUR VISIT TODAY, HAVE YOU HAD ANY RECENT TESTING OR IMAGING?
 CT SCAN
 MRI
 ULTRASOUND
 X-RAY
 SLEEP STUDY
 BARIUM SWALLOW
 BLOOD WORK
 IF YES, DATE _____
 FACILITY: _____

COMMON HERBAL MEDICATIONS:
 Aloe
 Arnica
 Bilberry
 Bromelain
 Dong Quai
 Echinacea
 Fatty Acids
 Fever Few
 Fish Oil Caps
 Flax Seed Oil
 Garlic
 Ginkgo
 Ginseng
 Goldenseal
 Hawthorne
 Kava Kava
 Licorice
 Parsley Seed
 Saw Palmetto
 St. John's Wart
 Valerian
 Vitamin E
 Yohimbe

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