

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:

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. 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.

Signature (Parent or Guardian if Patient a Minor)

Relationship To Patient

_____/_____/_____
Date

Please Print Name

_____/_____/_____
Patient's date of birth

Patients Name (if Minor)

MEDICAL HISTORY: N/A

Check all that apply

Yes No ANEMIA

Yes No ANGINA

Yes No ANXIETY

Yes No ASTHMA

Yes No AUTOIMMUNE DISORDER

Yes No BLEEDING DISORDER

Yes No BLOOD CLOTS

Yes No CANCER Type: _____

Yes No CURRENTLY PREGNANT

Yes No DEPRESSION

Yes No DIABETES

Yes No EMPHYSEMA

Yes No HEART ATTACK

Yes No HIGH BLOOD PRESSURE

Yes No HIGH CHOLESTEROL

Yes No KIDNEY DISORDER

Yes No LIVER DISEASE

Yes No PACEMAKER

Yes No PSYCHIATRIC PROBLEMS

Yes No REFLUX

Yes No SEIZURE DISORDER

Yes No SLEEP APNEA

If yes facility sleep study done _____

Yes No SLEEP APNEA ON CPAP

Yes No STROKE

Yes No THYROID DISEASE

Yes No TRAUMA

Yes No ULCERS

Type: _____

OTHER _____

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: _____

SURGICAL HISTORY: N/A

List all procedures patient has had

Yes No ADENOIDECTOMY

Yes No ANGIOPLASTY CORONARY BYPASS

Yes No APPENDECTOMY

Open surgery or laparoscopic? _____ Date? _____

Yes No BACK SURGERY

Yes No 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 _____

Yes No CANCER SURGERY Type: _____

Yes No COSMETIC NOSE SURGERY

Yes No EAR SURGERY

Yes No EAR TUBES

Yes No GALL BLADDER

Yes No HERNIA Type: _____ Date? _____

Open surgery or laparoscopic? _____ Date? _____

Yes No HYSTERECTOMY

Yes No JOINT SURGERY

Yes No NASAL SEPTUM SURGERY

Yes No PARATHYROIDECTOMY

Yes No SINUS SURGERY

Yes No THYROIDECTOMY

Yes No TONSILLECTOMY

Yes No COSMETIC SURGERY/ PROCEDURE

Type Date Physician

Yes No ABDOMINAL SURGERY/ PROCEDURE

Type Date Physician

OTHER _____

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: _____

REVIEW OF SYSTEMS: N/A

Check any you currently experience

Yes No FEVER

Yes No FATIGUE

Yes No NIGHT SWEATS

Yes No VISUAL LOSS

Yes No NOISE IN EARS

Yes No HEADACHES

Yes No SHORTNESS OF BREATH

Yes No COUGH

Yes No CHEST PAIN

Yes No PALPITATION

Yes No LEG CRAMPS

Yes No VOMITING

Yes No DIARRHEA

Yes No CONSTIPATION

Yes No BLOODY URINE

Yes No DIFFICULTLY URINATING

Yes No GENITAL DISCHARGE

Yes No BREAST DISCHARGE/ MASS

Yes No COLD HEAT INTOLERANCE

Yes No DIZZINESS

Yes No EMOTIONAL DISTURBANCE

Yes No RASH ITCHING

Yes No BACK JOINT PAIN

Yes No EASY BRUISING BLEEDING

Yes No ALLERGIES:

Inhalent _____ / Food _____ / Environmental _____

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:

Aloe Ginseng

Arnica Goldenseal

Bilberry Hawthorne

Bromelain Kava Kava

Dong Quai Licorice

Echinacea Parsley Seed

Fatty Acids Saw Palmetto

Fever Few St. John's Wart

Fish Oil Caps Valerian

Flax Seed Oil Vitamin E

Garlic Yohimbe

Gingkgo

PHARMACY FOR REFILLS: *PLEASE FILL IN

Name: _____

Location: _____

*Referring MD _____

*PCP _____