

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 plan 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
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Name	Relationship to Patient
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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

 Please Print Name

____/____/____
 Date

 Patients Name (if Minor)

____/____/____
 Patient's date of birth

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

ILLCIT 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: _____
 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: _____

LYMPH NODE DISSECTION

Yes No LYMPH NODE DISSECTION
 Left or Right? _____
 Yes No LYMPH NODE BIOPSY
 Left or Right? _____
 Date Last Ultrasound _____
 Date Last MRI _____

COMMON HERBAL MEDICATIONS:

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

PHARMACY FOR REFILLS: *PLEASE FILL IN

Name: _____
Location: _____
***Referring MD** _____
***PCP** _____

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 / _____

PHARMACY FOR REFILLS: *PLEASE FILL IN

Name: _____
Location: _____
***Referring MD** _____
***PCP** _____

Sleep/ Snoring Questionnaire

First Name: _____ Last Name: _____

Please check YES or NO to all the statements.

	YES	NO
1. My family complains about my snoring		
2. People refuse to share a bedroom because of my snoring		
3. Experience loud snoring when sleeping on my back		
4. Experience loud snoring when sleeping on my side		
5. Experience loud snoring even when asleep sitting up		
6. I have been told I stop breathing during sleep		
7. I have been told I choke or gasp during sleep		
8. I wake up with a choking or gasping sensation.		
9. I wake up with my heart beating faster than usual.		
10. Experience nasal congestion, obstruction or discharge at night		
11. Dry mouth upon awakening		
12. Headaches upon awakening		
13. Waking up feeling tired		
14. Feeling exhausted despite sleeping for many hours		
15. Fighting sleepiness during daily activities		
16. Difficulty staying alert when I am required		
17. Decreased concentration		
18. Forgetfulness		
19. Taking more than 30 minutes to fall asleep on most nights		
20. Wake up during night and have hard time falling back asleep		
21. Waking up early and being unable to fall back asleep		
22. Need to use sleep aids or medications		
23. Unable to sleep at all		
24. "Restlessness of Legs" when lying down in bed before sleep		
25. Leg twitches during sleep		
26. Alcohol use before bed		

Epworth Sleepiness Scale

Patient's First Name: _____ Last Name: _____

How likely are you to doze or fall asleep in the following situations? Even if you have not done some of these things recently, try to remember how you have reacted in the past. Check the most appropriate response for each situation.

Situation:

	Never Doze	Slight Chance of Dozing	Moderate Chance of Dozing	High Chance of Dozing
Sitting and Reading?				
Watching TV?				
Sitting inactive in a public place? (ie: Theatre, Movie, Meeting)				
As a passenger in a car for an hour without a break?				
Lying down to rest in the afternoon at home when conditions permit?				
Sitting and talking to someone?				
Sitting quietly after a lunch without alcohol?				
In a car, While stopped in traffic for a few minutes?				