

PATIENT REGISTRATION

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

Date _____

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

Male Female Date of Birth ___/___/___ Age ___ Social Security # _____ Student Status: F/T P/T

Street _____ City _____ State _____ Zip _____

Home Tel. # (____) _____ Business Tel. # (____) _____ Your Cell # _____

Primary Doctor _____ Location (City) _____
(As listed on your insurance card)

Were you referred here by another physician? NO YES If yes, which one _____

Race: White
African American
Asian
American Indian
Other _____
Refuse to answer

Preferred Language: English
Spanish
Refuse to answer

Ethnicity: Hispanic or Latino
Not Hispanic or Latino
Refuse to answer

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 _____

Emergency Contact Name: _____ Relationship _____

Home Tel #: _____ Cell # _____

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 # _____

**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. **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.

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

 Signature (Parent or Guardian please sign if Patient a Minor)

 Relationship To Patient

 Please Print Name

 Date

 Patients Name (if Minor)

 Patient's date of birth

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 <input type="checkbox"/> Check all that apply	SURGICAL HISTORY: N/A <input type="checkbox"/> List all procedures patient has had	REVIEW OF SYSTEMS: N/A <input type="checkbox"/> Check any you currently experience
<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 Type Date Physician _____ _____ <input type="radio"/> Yes <input type="radio"/> No ABDOMINAL SURGERY/ PROCEDURE Type Date Physician _____ _____ <input type="radio"/> OTHER _____	<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 DIFFICULTY 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 _____
ALLERGIES TO MEDICATIONS: Please List. What reaction occurs? _____ _____ _____ _____ LATEX ALLERGY? YES NO	SOCIAL HISTORY: FOR CHILD: N/A <input type="checkbox"/> TOBACCO CURRENTLY SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> SMOKED IN PAST HOW MUCH? _____ ALCOHOL <input type="checkbox"/> DO NOT DRINK <input type="checkbox"/> DRINK SOCIALLY <input type="checkbox"/> DRINK DAILY CAFFEINE <input type="checkbox"/> NONE <input type="checkbox"/> _____ CUPS	IF PATIENT IS A CHILD: CHILD LIVES WITH <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> OTHER DAY CARE OUT OF HOUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO HOUSEHOLD SMOKE EXPOSURE? Household smoke
ILLICIT DRUGS: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> FORMER PLEASE LIST _____ _____ _____	<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 _____	MEDICATIONS CURRENTLY TAKING: List all prescription, non-prescription medications and herbal supplements./Dosage <input type="checkbox"/> NONE / _____ _____ _____
FAMILY HISTORY: N/A <input type="checkbox"/> Any close relatives with the following? <input type="radio"/> Yes <input type="radio"/> No ALLERGIES <input type="radio"/> Yes <input type="radio"/> No ALZHEIMERS <input type="radio"/> Yes <input type="radio"/> No ANESTHESIA REACTIONS <input type="radio"/> Yes <input type="radio"/> No ASTHMA <input type="radio"/> Yes <input type="radio"/> No ALCOHOLISM <input type="radio"/> Yes <input type="radio"/> No BLEEDING DISORDER <input type="radio"/> Yes <input type="radio"/> No BLOOD DISEASE <input type="radio"/> Yes <input type="radio"/> No BREAST CANCER <input type="radio"/> Yes <input type="radio"/> No CANCER (please circle below) Type: Ovarian / Colon / Thyroid / Breast Lung / Other: _____ <input type="radio"/> Yes <input type="radio"/> No DIABETES <input type="radio"/> Yes <input type="radio"/> No HEARING DEFICIENCY <input type="radio"/> Yes <input type="radio"/> No HEART DISEASE <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 DISEASE <input type="radio"/> Yes <input type="radio"/> No MENTAL ILLNESS <input type="radio"/> Yes <input type="radio"/> No MIGRAINES <input type="radio"/> Yes <input type="radio"/> No SEIZURE DISORDER <input type="radio"/> Yes <input type="radio"/> No STROKE <input type="radio"/> Yes <input type="radio"/> No THYROID DISORDER	PERTAINING TO YOUR VISIT TODAY, HAVE YOU HAD ANY RECENT TESTING OR IMAGING? <input type="radio"/> Yes <input type="radio"/> No CT SCAN <input type="radio"/> Yes <input type="radio"/> No MRI <input type="radio"/> Yes <input type="radio"/> No ULTRASOUND <input type="radio"/> Yes <input type="radio"/> No X-RAY <input type="radio"/> Yes <input type="radio"/> No SLEEP STUDY <input type="radio"/> Yes <input type="radio"/> No BARIUM SWALLOW <input type="radio"/> Yes <input type="radio"/> No BLOOD WORK IF YES, DATE _____ FACILITY: _____	COMMON HERBAL MEDICATIONS: <input type="checkbox"/> Aloe <input type="checkbox"/> Arnica <input type="checkbox"/> Bilberry <input type="checkbox"/> Bromelain <input type="checkbox"/> Dong Quai <input type="checkbox"/> Echinacea <input type="checkbox"/> Fatty Acids <input type="checkbox"/> Fever Few <input type="checkbox"/> Fish Oil Caps <input type="checkbox"/> Flax Seed Oil <input type="checkbox"/> Garlic <input type="checkbox"/> Gingkgo <input type="checkbox"/> Ginseng <input type="checkbox"/> Goldenseal <input type="checkbox"/> Hawthorne <input type="checkbox"/> Kava Kava <input type="checkbox"/> Licorice <input type="checkbox"/> Parsley Seed <input type="checkbox"/> Saw Palmetto <input type="checkbox"/> St. John's Wart <input type="checkbox"/> Valerian <input type="checkbox"/> Vitamin E <input type="checkbox"/> Yohimbe

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.