

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"/> <i>Check all that apply</i>	SURGICAL HISTORY: N/A <input type="checkbox"/> <i>List all procedures patient has had</i>	REVIEW OF SYSTEMS: N/A <input type="checkbox"/> <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 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 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 BRUISES <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 _____ _____ _____	MEDICATIONS CURRENTLY TAKING: List all prescription, non-prescription medications and herbal supplements./Dosage <input type="checkbox"/> NONE / _____ _____ _____ _____	COMMON HERBAL MEDICATIONS: <table style="width:100%; border: none;"> <tr> <td style="border: none; vertical-align: top;"> <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 </td> <td style="border: none; vertical-align: top;"> <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 </td> </tr> </table>	<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
<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			
FAMILY HISTORY: N/A <input type="checkbox"/> <i>Any close relatives with the following?</i>	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: _____	<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		

Sleep/ Snoring Questionnaire

First Name: _____ Last Name: _____

Patient's Date of Birth: _____

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?				