

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 email address and sign consent below. To opt out at anytime, call 203-791-9661

EMAIL ADDRESS: _____

Responsible 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 # _____

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 physicians listed 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 physician 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.

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
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

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*
- 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

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: _____

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 COUGH HEAT INTOI FRANCEL
 - 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
- Amica
- Bilberry
- Bromelain
- Dong Quai
- Echinacea
- Fatty Acids
- Fever Few
- Fish Oil Caps
- Flax Seed Oil
- Garlic
- Gingkgo
- Ginseng
- Goldenseal
- Hawthorne
- Kava Kava
- Licorice
- Parsley Seed
- Saw Palmetto
- St. John's Wart
- Valerian
- Vitamin E
- Yohimbe

BREAST HEALTH HISTORY

NAME _____

DATE ____/____/____

Have you ever had breast cancer? Yes _____ No _____

Have you ever had breast biopsy that showed lobular carcinoma in situ (LCIS) or ductal carcinoma in situ (DCIS)? Yes _____ No _____

How old are you? _____

How old were you when you had your first menstrual period? _____

How old were you when your first child was born? _____

(If you never had a child enter "0")

Did you breastfeed any of your children for at least one month? _____

Do you use or have you ever, used oral contraceptives? Yes _____ No _____

If so, for how many years? _____

Do you take or have you taken hormone replacement? (Estrogen, Premarin, Premphase, Estraderm, etc.) If so, for how many years? _____

Yes _____ No _____

When was your last menstrual period? _____

Do you do breast self-exams monthly? Yes _____ No _____

Yes _____ No _____

How many of your first-degree relatives (mother, sisters, daughters) have had breast cancer? _____

Please list all known cancer diagnoses in your family: breast, ovarian, prostate, and colon (include yourself: ex: breast, ovarian)

Relation (include maternal/paternal)	Type of Cancer	Age at Diagnosis

Please list chronologically from latest to earliest any past breast surgeries? (List type, date, and surgeon)

When was your last mammography? Where? _____ / _____

Have you ever had a breast biopsy? (Breast biopsy means removal of tissue from your breast to test for cancer) If yes, how many have you had? Yes _____ No _____ / _____

Did the doctor ever tell you that one of your biopsies showed atypical hyperplasia? (atypical hyperplasia is a precancerous condition) Yes _____ No _____

Have you had any other breast imaging done? Yes _____ No _____

If so, what were the results? _____

Have you ever been treated with or exposed to high dose radiation? Yes _____ No _____

Are you married, divorced, etc.? _____

How many children do you have and what are their ages? _____ / _____

What is your: Height: _____ Weight: _____ Bra size: _____

What is your race? White _____ Black _____ Asian _____ Hispanic _____

Please answer the following questions regarding your visit to our office:

Why are you here today? _____

Do you have?	Which Breast?	How Long?	Before Periods?	Noticed by you or your doctor?
Breast Lump				
Change in breast size, shape, color				
Dimpling or retraction of skin				
History of Trauma				
Breast pain/soreness				
Nipple discharge				