

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:

<hr/>	<hr/>
Name	Relationship to Patient
<hr/>	<hr/>
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 have been given an opportunity to review the posted notice to patients regarding physician ownership of Ridgefield Surgical Center, LLC.

<hr/>	<hr/>
Signature (Parent or Guardian if Patient a Minor)	Relationship To Patient
<hr/>	<hr/>
Please Print Name	Date
<hr/>	<hr/>
Patients Name (if Minor)	Patient's date of birth

BREAST HEALTH HISTORY

NAME _____

DATE ____/____/____

Have you ever had breast cancer?
 Have you ever had breast biopsy that showed lobular carcinoma in situ (LCIS) or ductal carcinoma in situ (DCIS)?

Yes _____ No _____
 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 _____

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				