PATIENT REGISTRATION

CONTACT INFORMATION: ALL INFORMATION IS REQUIRED FOR INSURANCE PURPOSES

NAME: (LAST) _____ (FIRST) _____ MI:_____
BIRTH DATE:_____ BIOLOGIC GENDER: ☐M ☐F IDENTIFYING GENDER: _____
CELL PHONE:_____ HOME PHONE:_____ WORK PHONE:_____
EMAIL:_____ _____ RACE/ETHNICITY: _____ COUNTRY OF BIRTH: _____
STREET:_____ APT#:_____ CITY:_____
STATE: _____ ZIP CODE: _____
VETERAN STATUS: ☐YES ☐NO ☐SPOUSE
PLEASE CHECK ONE: MARITAL STATUS: ☐M ☐S ☐D ☐W ☐SO
STUDENT: ☐FT ☐PT ☐N/A
WORKING STATUS: ☐FT ☐PT ☐RET ☐NOT EMPLOYED
OCCUPATION:_____

PHYSICIAN INFORMATION:

PRIMARY CARE PHYSICIAN:_____ REFERRING PHYSICIAN:_____
OTHER PHYSICIANS: _____

EMERGENCY CONTACT: YOUR SPOUSE/PARTNER/PARENT OR GUARDIAN INFORMATION (REQUIRED IF YOU ARE NOT THE PRIMARY INSURANCE SUBSCRIBER)

NAME: (LAST) _____ (FIRST) _____ MI:_____
BIRTH DATE:_____ BIOLOGIC GENDER: ☐M ☐F IDENTIFYING GENDER: _____
PHONE NUMBER/S:_____ RELATIONSHIP:_____
(ADDRESS IF DIFFERENT THAN PATIENT) STREET:_____ APT#:_____
CITY:_____ STATE: _____ ZIP CODE: _____
WORKING STATUS: ☐FT ☐PT ☐RET ☐NOT EMPLOYED WORK PHONE:_____
WORK ADDRESS: _____ *PLEASE CHECK ONE:* HIPAA CONTACT ☐YES ☐NO

ADDITIONAL EMERGENCY CONTACT (OPTIONAL):

NAME:_____ RELATIONSHIP:_____
PHONE NUMBER/S:_____ *PLEASE CHECK ONE:* HIPAA CONTACT ☐YES ☐NO

_____ _____
SIGNATURE OF PATIENT/GUARDIAN **DATE**

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*****MEDICAID IS NOT ACCEPTED AS PRIMARY OR SECONDARY*****
*****COPAY (IF APPLICABLE) IS EXPECTED AT THE TIME OF SERVICE*****

*****IF YOU DO NOT ATTEND AN APPOINTMENT WITHOUT GIVING 24 HOURS NOTICE, YOU WILL BE CHARGED A $50 NO SHOW FEE. BY SIGNING BELOW, YOU ARE CONSENTING TO PAY THIS FEE.*****

PLEASE READ THE FOLLOWING PARAGRAPH AND SIGN BELOW:

I hereby assign all medical/surgical benefits to which I am entitled to Rheumatology Specialists of CT for services performed by them. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not said charges are reimbursed by insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. I further permit a copy of this authorization to be used in place of the original. I also understand that if this account must be turned over to an attorney for collections, I will be responsible for all attorney and court fees.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN **DATE**

Rheumatology Specialists of Connecticut

HIPAA Communication

Consent for the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I, (PRINT FULL NAME) _____, understand that as part of my healthcare, Rheumatology Specialists of Connecticut, originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:
A basis for planning my care and treatment;
A means of communication among the health professionals who contribute to my care;
A source of information for applying my diagnosis and surgical information to my bill;
A means by which a third-party payer can verify that services billed were actually provided.
I understand and have been provided with a Notice of Information Practices that provides a complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing.

Office Policies and Procedures

1.) COPAY (IF APPLICABLE) IS EXPECTED AT THE TIME OF SERVICE:

I, (PRINT FULL NAME) _____, hereby assign all medical/surgical benefits to which I am entitled to Rheumatology Specialists of CT for services performed by them. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not said charges are reimbursed by insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. I further permit a copy of this authorization to be used in place of the original. I also understand that if this account must be turned over to an attorney for collections, I will be responsible for all attorney and court fees.

2.) NO SHOW POLICY

Please note we require 24 hours notice, one business day, for any changes to appointments, otherwise there is a $50 charge. If a patient is disputing a charge, they must contact the office.

HIPAA Privacy Restrictions

I, (PRINT FULL NAME) _____, give my permission for Rheumatology Specialists of Connecticut to contact me at the following numbers and to leave a message on my answering machine, voicemail, or mobile phone:
Messages Concerning Appointments: Mobile #: _____ Home #: _____ Work #: _____

Messages Concerning Medical Information (lab results, test results, etc) Mobile #: _____ Home #:_____ Work #: _____

I give my permission for Rheumatology Specialists of Connecticut to communicate with the following persons regarding my health care:

HIPAA CONTACTS		
Name	Phone #	Relationship

This authorization will be valid from this date until written notice of changes and/or cancellations is received in the offices of Rheumatology Specialists of Connecticut.

I fully understand and accept the terms of this consent.
Signature of Patient/Personal Representative/Guardian: **Date:**

_____ _____

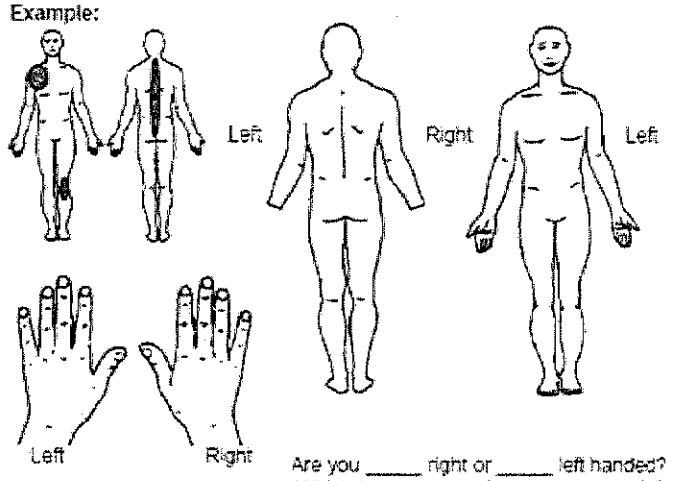
Medical History:

Check in the box if you have or had any of the following:

Stomach or peptic ulcer		Hepatitis or liver disease		Crohn's or Colitis	
Thyroid Condition		Kidney or bladder stones		Pulmonary embolism	
Anxiety		High BP		Blood clots	
Asthma		Emphysema		Pneumonia	
Goiter		Kidney disease		Tuberculosis	
Cataracts		Lymphoma		Diabetes	
Epilepsy		Depression		Jaundice	
Psoriasis		Heart problems		Hiv or aids	
Stroke		Heart murmur		Glaucoma	
Angina		Rheumatic fever		Leukemia	
Anemia		High cholesterol		Cancer	

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

Previous Surgeries/Operations:

Type	Year	Reason

1) What is your highest educational level?: ☐High school ☐College ☐Advanced degree _____

2) What occupation(s) have you had?: _____

3) Working status? ☐Full Time ☐Part time ☐Retired ☐Not employed ☐Sick leave ☐Disabled: _____

4) With whom do you currently live? _____

5) What kind of exercise do you do? How often?: _____

6) Do you smoke? ☐No ☐Yes: How much? _____ ☐ In the past: How long ago? _____

7) Do you drink alcohol? ☐No ☐Yes: How much? _____

8) Do you use drugs for reasons that are not medical? ☐No ☐Yes: _____

9) Do you have any family history of autoimmune disease? ☐No ☐Yes: _____

10) Please list any other significant illnesses: _____

Name: Last: _____ **First:** _____ **M.I.** ____ **Birthdate:** _____

Current Allergies

List all medication allergies, the type of allergic reaction, and the reason you were taking the medication.

Brand or Generic Name	Reason	Type of reaction

Current Medications

List all tablets, patches, drops, ointments, injections, etc. Please include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion or as needed.

Brand or Generic Name	Dose	How/when is it taken	Reason	Start date	Prescriber

PLEASE ATTACH ADDITIONAL PAGES IF NEEDED

Name: Last: _____ **First:** _____ **M.I.** ____ **Birthdate:** _____