Medical Specialists of Fairfield, LLC.

REGISTRATION FORM

Patient Last Name:___________________________________ **Middle Initial:**____**First Name:**___________________________

DOB:______________ **Age:**________**SSN:**_______________________**Marital Status:**_____**Race:**_________**Ethnicity:**_______

Street Address:____**City:**___________________**State:**____**Zip:**__

Alternate Address/P.O. Box:____**City:**________________**State:**_______**Zip:**__

Home Phone:_________________________ **Cell:**___________________________**Work:**______________________________

May we leave a message on your cell or home phone? Y/N | Email Address:____

In Case of Emergency Contact:_____________________________________**Relationship:**______________**Phone:**__________

Employer:____**Occupation**________________________________

Referring Physician:____**Primary Care Physician:**___________________________

Physician you are seeing today:__________________________ **Are you here due to an injury? Y / N If so, date of injury**____

Do you have a Living Will? Y / N Do you have a POA? Y / N Do you have a DNR? Y / N

**For more information on the above, please see attached info sheet on Advance Directives*

Have you had a Colonoscopy? Y / N If Yes, When?____________**Have you had a Mammogram? Y / N If Yes, When?**________

Immunizations, last date received: Influenza:_____________**Pneumonia:**_____________**Tetanus:**________________

Which Pharmacy do you use?______________________________**Which Radiology Facility do you use?**_________________

Are you a Jehovah's Witness? Y / N Date of last Physical:_______________________ **Have you had any other tests in the last**

X-Ray: Y / N Date:______________**MRI: Y / N Date:**_______________**CT Scan: Y / N Date**__________________

Labwork: Y / N Date:________________**Biopsy: Y / N Date:**____________________

INSURANCE INFORMATION

Primary Insurance:__________________________________ **Policy Holder name:**_____________________________________

Policy Holder DOB:__________**Policy Holder SSN:**_____________________ **Relationship to Patient:**______________________

ID Number:____ **Group Number:**_________________________**Referral Required?**

Secondary Insurance:________________________________**Policy Holder name:**______________________________ **Policy Hol**

DOB:________**Policy Holder SSN:**______________________ **Relationship to Patient:**__________________________________

ID Number:____ **Group Number:**_________________________**Referral Required?**

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand am financially responsible for any balance. I also authorize Medical Specialists of Fairfield, LLC. and/or my insurance company to release any in required to process my claims.

Patient Signature:____**Date:**___________________________

NEW PATIENT HEALTH HISTORY FORM

Patient Name: ____ **Birth date**: ____/____/____ **Date**: ____/____/_____

Referring Physician: __________________________________ Address: _______________________________________

Pharmacy Name: ____ Phone Number: ______-______-_______

Reason for today's visit: ____

Please describe this problem: ____

____

PRIOR SURGERIES	CURRENT/ PRIOR ILLNESSES/ INJURIES

Please list ALL medications (prescription and non- prescription) that you take. (Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions etc.)

MEDICATION	DOSAGE	MEDICATION	DOSAGE

Do you take any blood thinning products such as **Vitamin E, Plavix, Coumadin, or Aspirin**? ☐ **NO** ☐ **YES**

Do you have any food, environmental, or drug allergies? ☐ **NO** ☐ **YES** (Please explain below)

ALLERGY	TYPE	REACTION

Do you smoke? ☐ **NO** and Never have ☐ **YES** (Please explain below)

TYPE OF SMOKING (cigarette, pipe marijuana, chew, etc.)	HOW MUCH	HOW LONG

Do you drink alcohol? ☐ **NO** and Never have ☐ **Socially Only** ☐ **Daily** ☐ **Beer/ Wine** ☐ **Hard Liquor**

Occupation: ____ Hand Dominance: ☐ **RIGHT** ☐ **LEFT**

Please describe any family health issue below:

FAMILY HISTORY	GOOD/ NONE	UNKNOWN	ILLNESSES/ REASON FOR DEATH
MOTHER			
FATHER			
SIBLING(S)			
OTHER HEREDITARY ILLNESS			

Patient Signature: ____ Date: ____/_____/_____

Physician Signature: ____ Date Reviewed: ____/____/____

HEALTH HISTORY FORM 2

Do you have or have you ever had any of the following:

Symptoms/ Illness	**NO**	**YES, Explain**	**Symptoms/ Illness**	**NO**	**YES, Explain**
Constitutional			**Skin**		
Fever or Chills			Breast Abnormalities		
Weight Loss			Nipple Discharge		
Hematologic			**Last Mammogram**		**Date: ____/____/____**
Hepatitis			Changes in Moles		
HIV/ Other Blood Diseases			Lesions		
Bleeding Disorders			Rashes		
Endocrine			History of Keloids		
Thyroid Problems			**Neurological**		
Diabetes			Neurological Problems		
Musculoskeletal			Headaches		
Arthritis			**GENITOURINARY**		
Mobility/ Joint Problems			Genital or Oral Herpes		
GASTROINTESTINAL			S.T.D.'s		
Constipation			Blood in Urine		
Diarrhea			Urinary Tract Infection		
Blood in Stool			Problems Urinating		
Nausea/ Vomiting			Prostate Problems		
Liver Problems			Kidney Problems		
CARDIOVASCULAR			**Eyes**		
Heart Problems			Vision Problems		
Deep Vein Thrombosis/ DVT			**ENT**		
Blood Clots in Lungs/ Legs			Hearing Problems		
High Blood Pressure			Sinus Problems		
RESPIRATORY			**PSYCHIATRIC**		
Asthma			Mood Swings		
Sleep Apnea			Anxiety/ Depression		

Please list any other conditions/ illnesses not indicated above: ____

____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

Patient Signature: ____ **Date:** ____/____/____

Physician Signature: ____ **Date Reviewed:** ____/____/____

Medical Specialists of Fairfield, LLC.

ACCEPTANCE OF LIABILITY

Patient name:__________________ Account Number:__________________

Date of Birth:___________________ Practice Location:__________________

I understand that I may be responsible for charges not covered or reimbursed by my insurance carrier. The reasons indicated below states why your insurance carrier may not reimburse us for the service/treatment you receive at our office.

1) You may have a major deductible or out of pocket expense.

2) No referral obtained from your primary care physician.

3) Your insurance carrier does not pay and/or cover services provided.

Signature:______________________________ Date:__________________________

In the event that you have out of pocket expenses related to services and/or treatment given in our office, you may be eligible to receive financial assistance. Please check the box below if you would like to be contacted by our Financial Counselor.

☐ I would like more information regarding financial assistance.

**Please note this does not include co-pays for office visits.

ADVANCE DIRECTIVE

An advance directive is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions.

There are two main types of advance directives — the "*Living Will*" and the "*Durable Power of Attorney for Health Care*."

I. LIVING WILL

A Living Will is the oldest type of health care advance directive.

It is a signed, witnessed (or notarized) document called a "declaration" or "directive." Most declarations instruct an attending physician to withhold or withdraw medical interventions from its signer if he/she is in a terminal condition and is unable to make decisions about medical treatment.

Family members and others who are familiar with the signer's values and wishes have no legal standing to interpret the meaning of the directive.

II. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

A Durable Power of Attorney for Health Care is a signed, witnessed (or notarized) document in which the signer designates an agent to make healthcare decisions if the signer is temporarily or permanently unable to make such decisions.

Unlike most Living Wills, the Durable Power of Attorney for Health Care does not require that the signer have a terminal condition.

III. DNR

A do-not-resuscitate order, or DNR order, is a medical order written by a doctor. It instructs health care providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating.

Medical Specialists of Fairfield, LLC.

Authorization for Release of Information

Patient Name:______________________________________Date of Birth:_____________

Many of our patients allow family members or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released, you must sign this form. Signing this form will only give information to the individuals indicated below.

Medical Specialists of Fairfield, LLC. to release my medical and/or billing information to the following individual(s):

1. __________________________________ Relation to Patient:_________________________
2. __________________________________ Relation to Patient:_________________________
3. __________________________________ Relation to Patient:_________________________

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient.

Signature:______________________________________Date: ___________________

Medical Specialists of Fairfield, LLC.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read and/or received a copy of the Medical Specialists of Fairfield, LLC. Patient Notice of Privacy Practices effective December 8, 2017.

Patient Signature: ____Date of Birth:__________________

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Please let us know your preferred method of contact below:

☐ **Please contact me at home.**

☐ **Please contact me at work.**

☐ **Please contact me on my cell.**

☐ **Please send me mail, including my bills, to this alternate address:____**

☐ **Please do not leave messages on my answering machine.**

☐ **Please do not mail appointment cards to me.**

☐ **Please do not contact me by email.**

☐ **Other Request: (please describe):**

____

____

Patient Signature:_____________________________________Date:___________________

Office Policies of Medical Specialists of Fairfield, LLC.

A physician is on call for emergencies 24 hours a day, 7 days a week and may be reached by calling any of our offices after hours. We have three locations: 425 Post Road, South Lobby, Fairfield, CT 06824 #203-255-4545, our SWIM Hematology Oncology office inside the Elizabeth M. Pfriem Swim Center for Cancer Care at St. Vincent's Medical Center, 2800 Main Street, 3rd floor, Bridgeport, CT 06606 #203-382-2475, and in Commerce Park, 4699 Main Street, Suite 204, Bridgeport, CT 06606 (Dr. Aleali only) #203-371-5228.

Co-pays: We participate in most insurance plans. Co-payments are required and payable at the time of visit. For your convenience we accept Discover, Mastercard and VISA, American Express, as well as cash and personal checks made payable to Medical Specialists of Fairfield. Please be prepared to pay your co-pay at the time of service.

If you do not have insurance coverage, payment in full is expected at the time of service.

Referrals: Your insurance carrier may require a referral or an authorization prior to your visit to be seen by one of our doctors. It is important to obtain this authorization from your primary doctor; otherwise, you may be responsible for payment of the visit.

Missed Appointments: We require at least 24 hours notice in the event of a cancellation. Monday appointments must be cancelled by 3PM on the previous Friday. Multiple missed appointments will result in termination from the practice.

As a courtesy, we attempt to call our patients to remind them of their appointments. Please indicate on your patient registration form which number you prefer us to call. You are expected to keep track of your appointments and not receiving a call to confirm it will not be an acceptable excuse for missing an appointment.

Prescription refills: We request that you allow us 24 hours to call in a refill prescription for you. Prescription refill requests must be requested before 3PM, Monday – Friday. Physicians in the group who are covering on nights and weekends are not familiar with the history of patients not under their care and will not be able to refill medications for more than enough medication to last until your own physician is available whether that be the next morning or after the weekend. Stimulants and narcotic medications can not be refilled by a covering physician.

Parking for patients and visitors: (For SWIM Hematology Oncology office)
Parking is permitted in the following areas, the main parking lot across from the main medical center entrance, and the Hunting Street Garage. Please bring your parking ticket into the front office so we can validate it for you.