

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 \_\_\_\_\_ Parent/Guardian Date of Birth \_\_\_/\_\_\_/\_\_\_

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 and 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 # \_\_\_\_\_

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:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
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 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 if Patient a Minor)

\_\_\_\_\_  
Relationship To Patient

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Patients Name (if Minor)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient's date of birth

## 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?				