

# 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  
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. 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.

\_\_\_\_\_

Signature (Parent or Guardian if Patient a Minor)

\_\_\_\_\_

Relationship To Patient

\_\_\_\_\_

Please Print Name

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date

\_\_\_\_\_

Patients Name (if Minor)

\_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's date of birth



## 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? Yes \_\_\_\_\_ No \_\_\_\_\_  
(atypical hyperplasia is a precancerous condition)

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				