Hartford HealthCare Medical Group

NEW PATIENT REGISTRATION INFORMATION

Patient Legal Name (Last) ______________ (First) ______________ (MI) _____ ☐ M ☐ F

DOB ______________ **Marital Status:** (please circle) M S D W **SSN#** ______________

Address ______________ **City** ______________ **State** _______ **Zip Code** __________

Phone: Home (____)__________ **Cell** (____)__________ **Work** (____)__________ **Ext** _____

Email Address: ______________@______________

Emergency Contact ______________ **Relationship** ______________ **Phone** (____)__________

Do you have any pending paperwork related to today's visit? (ex. FMLA, Disability Insurance, Social Security Forms) ☐ Yes ☐ No

If yes, please list the type of paperwork.______________

Primary Care physician: ______________ **Referring physician/source** ______________

Pharmacy:______________ **Address, City, State** ______________ **Phone**______________

Employer:______________ **Address**______________ **City**______________ **State**_____ **Zip**_______

Primary Insurance Carrier

Insurance Company______________ **Identification/Member #** ______________

Group Name/Number ______________

Subscriber's Name *(as it appears on insurance card)* ______________ ☐ M ☐ F

Subscriber's Date of Birth ______________ **Subscriber's Social Security#** ______________

Subscriber's Employer: ______________ **Relationship to Patient** ☐ Self ☐ Spouse ☐ Child

Secondary Insurance Carrier

Insurance Company______________ **Identification/Member #** ______________

Group Name/Number ______________

Subscriber's Name *(as it appears on insurance card)* ______________ ☐ M ☐ F

Subscriber's Date of Birth ______________ **Subscriber's Social Security#** ______________

Subscriber's Employer: ______________ **Relationship to Patient** ☐ Self ☐ Spouse ☐ Child

**** ONLY COMPLETE IF YOU HAVE AN APPROVED WC CASE ** Incident Related Injury**

Is your visit related to a work related injury? ☐Yes ☐ No **Is this related to a motor vehicle accident?** ☐ Yes ☐ No

If you responded ***YES*** *to either question above please complete the following section(s)*

Date of Injury ______________ Claim #______________Body part(s) affected ______________

Insurance Carrier ______________ Policy #______________

Insurance Carrier Address______________ City ______________State _______ Zip_______

Contact person ______________Phone# (____)______________

If a work place injury, are you a state of Connecticut employee?

☐ Yes, what Department______________ ☐ No *Other Employer Name & Address*______________

Human Resource Contact______________Phone______________

Attorney's Name *(if applicable)* ______________Phone______________

Meaningful Use Data Collection

HHC Medical Group is collecting patient information to assist in understanding our patient population, so we can develop the capability, where needed, to provide culturally appropriate medical care and advise. Please assist us by completing the following (*circle your answer*):

a. **Preferred Language:** English French Italian Polish Spanish Other________
b. **Self-Identified Race:** American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White/Caucasian Unknown Other________
c. **Self-Identified Ethnicity*:** Hispanic/Latino Not Hispanic/Latino Unknown Declined
d. **Are you a Veteran:** Yes No

**These race and ethnicity categories are from the U.S. Dept. of Health and Human Service Office of Management and Budget Standards for the Classification of Federal Data on Race and Ethnicity – 2003.*

I hereby authorize Hartford Healthcare Medical Group to furnish information to insurance carriers concerning my injury and/or illness and treatment, and I hereby assign to the physician(s) all payments for medical services rendered. I understand that I am responsible for all charges whether or not such charges are covered by insurance.

____
Patient signature / Date

____
Parent or Guardian Signature / Date
If patient is a minor (under age of 18) or has a guardian/conservator, this must be signed by the parent or legal guardian.

Name: ______________________________ Date:____/____/____

Date of Birth: ___/___/_____ Age: _______ Gender: Male___ Female____

Present Problem:

Describe your current discomfort or the reason for your visit:	
When was the on-set of symptoms?	Cause of discomfort/symptoms?
What makes your symptoms worse?	
Do you have weakness?: Yes No Where?: ______________________	Do you have numbness ?(circle): Yes No Where?: ______________________

What treatments have you tried? (check therapies and add additional information) :

- ☐ Physical therapy, name and location? ______________________
- ☐ Injections: With whom/type? ______________________
- ☐ Medications: Which ones? ______________________
- ☐ Modification of activity/rest

Is this a work related injury? (circle): Yes No If yes, date of injury: ___/___/____ Employer:______________________

Is there a lawsuit in regards to the injury?: Yes No Does a lawyer represent you?: Yes No

If yes, name/location/phone number?______________________

Past Medical History: Do you currently have or have you ever been treated for any of the following medical conditions? **Please circle the specific condition if there is more than one listed**.

Condition	Yes	No	Condition	Yes	No
Asthma			Ulcers/Acid Reflux/GERD		
Tuberculosis			Osteoporosis/Osteopenia		
COPD			Hypo/Hyperthyroid		
Heart disease/Pacemaker			Diabetes mellitus Type I/Type II		
Heart Attack/Pacemaker			Renal Failure/Kidney Disease		
High Blood Pressure			Hepatitis/Liver Disease Cirrhosis		
High Cholesterol			Cancer:		
Peripheral Vascular Disease			Sexually Transmitted Disease:		
Anemia			HIV/AIDS		
Blood Transfusion			Medication Dependency		

Pre-established Specialists: Please list physicians you have seen or are currently treating with:

Cardiologist:	Pain Management:	Pulmonologist:
Hematologist:	Endocrinologist:	Gastrointestinologist:
Gynecologist:	Hepatologist (liver):	Immunologist:
Neurologist:	Neurosurgeon:	Oncologist:
Orthopedics:	Rheumatologist:	Other:

Name: ________________________________ Date:___/___/____ Date of Birth:___/___/____

Medications: List ALL medications or supplements

Medication/supplement	Dosage	Medication/supplement	Dosage

Allergies:

Please list any allergies that you have to food, medications, or materials such as latex...

____

____

Past Surgical History: Please list any previous hospitalizations or surgeries you have had, dates and surgeon.

Social History:

Height:_______ Weight______ Occupation________________________________

Exercise level? (circle) **None** **1-2 times/week** **3+ times/week**

Do you drink Alcohol? (circle) **Yes** **No** Number of days a week? ____ Number of drinks per week? ____

Do you use Tobacco/Nicotine? (circle) **Yes** **No** **Quit** If you quit, when did you do so? _____________

What kind of product do you use? (circle) **Cigarette** **Cigar** **Chew** **Smokeless/Vape** **Other**

If you smoke, please indicate how many packs or cigars you smoke per day:______________________

If you vape, does it have nicotine? (circle) **Yes** **No**

Review of Symptoms: Do you experience any of the following? Circle all that apply.

__Appetite change
__Activity change
__Fever/chills
__Fatigue
__Unexpected weight gain/loss
__Dental pain
__Tinnitus
__Hearing loss
__Sore throat
__Nose bleeds
__Frequency/urgency to urinate
__Visual disturbance
__Glasses/contacts
__Wheezing
__Shortness of breath
__Cough
__Apnea
__Heart Murmur
__Chest pain/angina
__Palpitations
__Nausea/Vomiting
__Depression/anxiety
__Diarrhea/Constipation
__Bloody Stool
__Abdominal pain
__Bruises/Bleeds easily
__Blood clots/DVT/PE
__Headaches
__Facial asymmetry
__Tremors
__Seizures
__Sleep disturbance

Family History: Please indicate family members who have been diagnosed with any of the following:

Lung Disease__________________________
Problem with Anesthesia________________
Cancer______________________________
Leukemia____________________________
Heart Disease_________________________
High Blood Pressure____________________
Arthritis_____________________________
Stroke______________________________
Diabetes_____________________________
Other_______________________________

Hartford HealthCare
Medical Group
Connect to healthier.™

6816

Communicating with Family and Friends Form

Request for Verbal Communication of Protected Health Information

Patient Name: ______________________ **Patient Date of Birth:** ______________

Patient Address: ______________________________ **Apt. #:** ____________

City: ____________________ **State:** _____ **Zip Code:** __________

Telephone Contact #: Home: (   ) ____________ **Cell: (   )** ____________

Preferred: ☐ **Home** ☐ **Cell** ☐ **Other:** ____________________

Verbal Sharing of Confidential PHI with Others

By signing below, I give permission for my care team to **discuss** my (or my child's) protected health information (including diagnosis, diagnostic test results, examination information, claim information, and appointment confirmations) with the individuals specified below when/if these individuals request information on my behalf or if my care team believes it is in my best interest. This permission is specific to **my (or my child's) treatment or care at** ______________________.

(Hartford HealthCare Facility or Office)

The purpose of the form is to grant permission for members of my (or my child's) care team to verbally share information with the individuals involved in my (or my child's) care, specified below. Any requests for a releases of written information, such as all information contained in my (or my child's) medical record, will require me to complete and sign a written authorization for Disclosures of Protected Health Information.

I understand that I may revoke this permission at any time. If I want to revoke this permission, I will call the office immediately and complete a new form to restrict future communications to the below individuals.

The above Hartford Healthcare Facility or Office may verbally share patient information regarding my current treatment or care with the individuals listed below.

(1) Name: ______________________ Relationship: ____________ Phone: ____________

(2) Name: ______________________ Relationship: ____________ Phone: ____________

(3) Name: ______________________ Relationship: ____________ Phone: ____________

I have carefully read and understand all of the above. All of my questions have been answered. I understand that my care team may continue to share verbal information with the individuals listed above until I notify the office, in writing, of my decision to change it.

Patient/Legal Representative Signature: ______________________ **Date:** __________ **Time:** ________

Print Name: ______________________ **Relationship to Patient:** ______________________