## PATIENT IDENTIFICATION

☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Dr. DATE_____

| | | | |
|---|---|---|---|
| Patient's Name: | Last | First | MI |
| Address: | Street City State | | Zip code |
| Email: | | DOB: | |
| Home Phone: | Cell Phone: | Work Phone: | |
| Sex: ☐ M ☐F | Race: ☐White ☐Black ☐Indian ☐Asian ☐Hispanic ☐Other | | |
| Ethnic Background: | Language: | SS# | |
| Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated | | | |
| Employer: | | Occupation: | |
| Spouse's Name: | | DOB: | |
| Spouse's Address: | | | |
| Spouse's Employer: | | Phone: | |
| Emergency Contact: | Name Address Phonr# | | |
| Pharmacy: | Name Address (street, city, state, zip) Phone# | | |

**IF THE PATIENT IS A MINOR, STUDENT OR ANOTHER PARTY RESPONSIBLE FOR PAYMENT**

| | | |
|---|---|---|
| Responsible Party/Guarantor(s): | | Relationship: |
| Address: | | DOB: |
| Home Phone: | Cell Phone: | Work Phone: |

**INSURANCE INFORMATION**

| | | |
|---|---|---|
| Primary: ☐Medicare ☐State Welfare ☐Other Insurance | | Name of Insured: |
| ID# | Group# | DOB: |
| Secondary: ☐Medicare ☐State Welfare ☐Other Insurance | | Name of Insured: |
| ID# | Group# | DOB: |
| Is it Worker's Compensation? | | |
| If yes, name of your company & contact person: | | |
| Referring Doctor: | Name Address Phone# Fax # | |
| Primary Care Doctor: | Name Address Phone# Fax # | |

If we participate with your insurance company we will submit your claim to them, but we cannot be responsible for errors or delay in the filling out and/or submission of insurance forms if we do not have the proper insurance card.

**Regardless of any insurance coverage I/we may not have, it is my/our responsibility to pay the entire bill. In the event that this office needs to obtain legal assistance in collection of any unpaid balance, I/we agree to pay costs and attorney fees, as allowable by law and acknowledge receipt of a photocopy of this agreement.**

| | |
|---|---|
| Signature | Signature |
| | Parent, Guardian or responsible party |

Authorization to release my medical records for billing purposes is granted by me.

| | |
|---|---|
| Signature | Signature |
| | Parent, Guardian or responsible party |

*****PLEASE PRESENT INSURANCE CARD AT THE TIME OF EACH VISIT*****

**PATIENT HISTORY** DATE _____ CHART NO. _____

NAME _____ DATE OF BIRTH _____ AGE _____

**ALLERGIES TO MEDICATIONS:** _____

**MEDICATIONS**

1. _____
2. _____
3. _____
4. _____
5. _____

**REFERRAL M.D.** _____

**OCCUPATION** _____

**SOCIAL HISTORY: Marital status:** M____ S____ D____ W____

**Cigarettes (packs/day)** _____ **Alcohol (drinks/day)** _____

**Recreational Drugs** _____

**PRIOR SERIOUS ILLNESS / MEDICAL CONDITIONS:**

1. _____
2. _____
3. _____
4. _____

**Pertinent Medical History about your Family**

1. _____
2. _____
3. _____
4. _____

**HOSPITALIZATIONS / SURGERY (give date and reason):**

1. _____
2. _____
3. _____
4. _____

**REVIEW OF SYSTEMS (check all):**

Yes No **1. General**
- ___ ___ weight loss
- ___ ___ weakness / fatigue
- ___ ___ fever / night sweats

**2. Eyes:**
- ___ ___ dryness / redness
- ___ ___ blurred / double vision
- ___ ___ glaucoma

**3. Heart and Circulation:**
- ___ ___ chest pain
- ___ ___ irregular heartbeats
- ___ ___ heart murmur
- ___ ___ leg swelling
- ___ ___ high blood pressure
- ___ ___ rheumatic fever

**4. Lungs:**
- ___ ___ shortness of breath
- ___ ___ cough
- ___ ___ coughing up blood
- ___ ___ tuberculosis
- ___ ___ emphysema
- ___ ___ asthma

**5. Stomach and Intestines:**
- ___ ___ nausea / vomiting / diarrhea
- ___ ___ heartburn / reflux

Yes No
- ___ ___ jaundice/hepatitis
- ___ ___ spitting up blood
- ___ ___ black stools

**6. Kidneys and Genitals:**
- ___ ___ pain / burning on urination
- ___ ___ bloody / cloudy urine
- ___ ___ penile / vaginal discharge
- ___ ___ genital rash / ulcers
- ___ ___ venereal disease
- ___ ___ kidney stones

**7. Muscles and Joints:**
- ___ ___ muscle weakness / pain
- ___ ___ joint pain / swelling
- ___ ___ arthritis / gout

**8. Skin and Glands:**
- ___ ___ dryness
- ___ ___ rash
- ___ ___ growths / discoloration
- ___ ___ swollen glands

**9. Neurological:**
- ___ ___ headache
- ___ ___ numbness / weakness
- ___ ___ neuralgia
- ___ ___ off balance / dizziness

Yes No
- ___ ___ seizure
- ___ ___ stroke
- ___ ___ Bell's palsy

**10. Psychiatric:**
- ___ ___ anxiety
- ___ ___ depression
- ___ ___ delusions / hallucinations
- ___ ___ medications

**11. Hormones:**
- ___ ___ thyroid disorder
- ___ ___ diabetes ("sugar")
- ___ ___ irregular menses

**12. Blood:**
- ___ ___ bleeding tendency
- ___ ___ easy bruising
- ___ ___ anemia

**13. Immune System:**
- ___ ___ frequent infections
- ___ ___ positive HIV test

**14. If Child:**
- ___ ___ immunization up to date
- ___ ___ feeding difficulties

The information is to the best of my knowledge accurate and complete. PATIENT SIGNATURE: _____

Reviewed and updated. PHYSICIAN SIGNATURE: _____

## Acknowledgement of Receipt of Notice of Privacy Practices

Dr. Ned Ramadan
228 New Haven Ave.
Milford, CT 06460
(203)701-0252

Name of Patient:_____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. 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.

### HIPPA Questions

As my doctor, you or your staff may:

(Please check appropriate boxes)

A. [ ] Call my home/cell phone and if necessary leave a message on the answering machine/voicemail/with a family member for me to call you back to schedule an appointment or to return your call.
B. [ ] Call my home/cell phone and if necessary leave a message on the answering machine/voicemail/with a family member giving a test result.
C. [ ] Call my home/cell phone and if necessary leave a message on the answering machine/voicemail/with a family member inquiring how I am dong.
D. [ ] Call my workplace and if necessary leave a message for me to call you back.

(The above instructions are valid for 12 months.)

Signed:_____Date:_____

Print name:_____Phone:_____

If not signed by patient, please indicate your relationship to the patient:_____


# IMPORTANT INFORMATION – PLEASE READ

**To our patients:**

**Please take note that we are forced to change our billing policies.**

**We do accept insurance assignment for your visits, but many of the commercial insurance plans have a high deductible causing a large balance on your account. In order to increase our efficiency, we will require a credit card at the time of check-in, to cover those high deductibles.**

**The information will be held in a secure area until it is determined what your balance is. It usually takes 2-3 weeks before we receive an insurance Explanation of Benefits (EOB). Once received, we will call you for permission to use your credit card. If you are not at home we will leave a message. If we do not hear from you in two days we will bill your credit card for the balance and send you a copy of the credit card receipt and the EOB.**

**Payment in this manner will be an advantage to you and us. You will no longer have to mail in payment or call in your credit card information and for us it will save us from sending out a bill. We will still collect co-pays at the time of visit.**

**Thank you for your cooperation.**

_____

Signature