

<b>PATIENT DEMOGRAPHICS:</b>				
Last Name:		First:		MI:
Address:				
City:		State:	Zip:	
Please check off the phone numbers you would like us to call regarding appointment conformations. <b>May we leave a message?</b> YES      NO		<input type="checkbox"/> Home:		
		<input type="checkbox"/> Cell:		
		<input type="checkbox"/> Work:		
DOB:		Sex M___ F___	SSN:	
<b>Email Address:</b>				
Race:		Marital Status:	M___ S___ D___ W___	
Occupation:		Employer's Name:		
Emergency Contact:		Relationship:		
Home Phone		Cell Phone:	Work:	
<b>Primary Insurance:</b>				
Name of Insured:		Relationship:	DOB	
Employer of Insured:				
<b>Secondary Insurance:</b>				
Name of Insured:		Relationship:	DOB	
<b>Pharmacy Name:</b>			Pharmacy Phone:	
Pharmacy Address:				
<b>How did you hear about our practice?</b>		<b>PLEASE LIST ALL THOSE INVOLVED IN YOUR HEALTH CARE</b>		
Friend/Family:		Primary Care Doctor:		
Advertisement:    Where?		OBGYN:		
Insurance Company:		Cardiologist:		
Employer:		Please list any other doctors:		
Walk/Drive-by:				
Other:				

In order to submit a claim for payment for the services covered under your policy, we must have your authorization to release medical information to your insurance company.

I authorize any holder of medical information to release it to my insurance carrier or its intermediaries for any claim purposes. I request that payment be made on my behalf. I understand that I am responsible for any balance not covered by this authorization or any balance unpaid by my insurance company.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**SOCIAL HISTORY**

	YES	NO		YES	NO
Alcohol consumption			Tobacco Use		
How Much Per Day?			How Much?		
Sexually Active			Drugs?		
Exercise			Caffeine (Coffee/tea soda)		
Pets in Home			How Much Per Day:		
Ever had a blood transfusion?					

**GYN HISTORY**

Did you start your menstrual period before age 12?	Did you breastfeed:				
Date of LMP:	If Post-menopausal, age at menopause:				
Number of Pregnancies:	Bra Size:				
Number of live births:	Date of Last Breast Imaging:				
Age at First Child:	Have you ever had a breast biopsy:				YES or NO
Are you nulliparous (never given birth) YES or NO	Results:				
	Have you ever taken estrogen for hormone Replacement therapy (HRT) If yes, how many years? _____				YES or NO
Have you ever been told you have dense breasts YES or NO	Have you been tested for BRCA1/BRCA2 Results				YES or NO

**FAMILY HEALTH HISTORY**

Do you have any of your 1 <sup>st</sup> degree relatives that are of Ashkenazi descent? YES NO						
	AGE	ALIVE	DECEASED	UNKNOWN	HISTORY OF CANCER?	NOTES:
MOTHER						
FATHER						
SIBLING						
SIBLING						
SIBLING						
GRANDMOTHER						
GRANDMOTHER						
GRANDFATHER						
GRANDFATHER						
AUNT						
OTHER						

## PAST MEDICAL HISTORY

	YES	NO	NOTES		YES	NO	NOTES
Acid Reflux				Fibromyalgia			
Alcoholism/Substance Abuse				Glaucoma			
Anemia				Heart Attack			
Anxiety Disorder				Heart Disease			
Any blood relative who had anesthesia complications				High Blood Pressure			
Complications related to anesthesia				High Cholesterol			
Arrhythmia				Intestinal Problems-Ulcer, Hiatal Hernia			
Arthritis				Jaundice or Liver Disease			
Asbestos Exposure				Kidney Disease or Problems			
Asthma or Allergies				Lung Disease (Pneumonia, TB, Emphysema)			
Auto Immune Disease				Migraine Headaches			
Bladder Disease				Palpitation			
Bleeding Tendencies				Obesity			
Blood Clotting in lungs or legs				Osteopenia or Osteoporosis			
Breast Disease				Rheumatic Fever			
Cancer				Seizures, Convulsions, Epilepsy			
Cataracts				Sickle Cell Disease			
Angina Pectoris				Sleep Apnea			
Congestive Heart Failure				Stroke			
COPD				Thyroid Problems			
Depression, Mental illness				Venereal Disease			
Diabetes				Vitamin Deficiency			
Eczema				Genetic Mutation			
Fainting Spells							

## REVIEW OF SYSTEMS

Please **Circle** Each Item As They Relate To Your Health

### **Constitutional:**

Fatigue  
Fever  
Exercise intolerance  
Night sweats  
Significant weight gain  
Weight gain (\_\_\_\_ lbs)  
Significant weight loss  
Weight Loss (\_\_\_\_ lbs)

### **Skin:**

Abnormal Moles  
Jaundice  
Hives  
Eczema  
Rashes  
Mole(s) changes

### **Eyes:**

Dry Eyes  
Irritation  
Vision Change  
Discharge

### **Ears Nose Mouth Teeth:**

Hearing loss  
Ear Pain  
Sneezing Frequent  
Nosebleeds  
Bleeding gums  
Snoring  
Dry Mouth  
Mouth Ulcers  
Teeth Problems  
Headaches  
Oral Abnormalities  
Nose/Sinus problems  
Sore Throat  
Frequent Nosebleeds  
Teeth Abnormalities  
Frequent or Severe headaches

### **Neck Symptoms:**

Swollen Glands  
Neck Stiffness

### **Pulmonary Symptoms:**

Cough  
Wheezing  
Shortness of Breath  
Coughing up Blood

### **Cardiovascular Symptoms:**

Chest Pain  
Shortness of Breath when Walking  
Shortness of Breath when Laying  
Down  
Leg Swelling  
Palpitations  
Arm Pain on Exertion

### **Gastrointestinal Symptoms:**

Abdominal Pain  
Vomiting  
Vomiting Blood  
Normal Appetite  
Diarrhea  
Constipation  
Rectal Bleeding  
History of GERD  
Change in Appetite  
Black or Tarry Stools  
Frequent Diarrhea  
Feeling Full Before Finishing Meals  
(Early Satiety)

### **Genitourinary Symptoms:**

Incontinence  
Difficulty Urinating  
Hematuria  
Increase Frequency  
Urinary Frequency  
Incomplete Emptying  
Urinary Loss of Control

### **Musculoskeletal Symptoms:**

Muscle aches  
Muscle Weakness  
Arthralgias/Joint Pain  
Back Pain

### **Neurological Symptoms:**

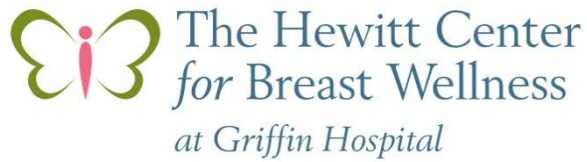
Loss of Consciousness  
Weakness  
Numbness  
Seizures  
Dizziness  
Loss of Balance

### **Psychological Symptoms:**

Depression  
Anxiety  
Sleep Disturbances  
Feeling Safe in Relationship  
Homicidal Thoughts  
Suicidal Thoughts  
Alcohol Abuse

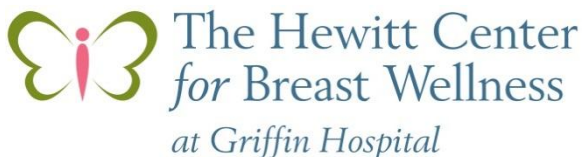
### **Gynecological Symptoms:**

Hot Flashes  
Menstrual Bleeding  
Vaginal Pain  
Vaginal Itching or Burning  
Vaginal Discharge  
Issues with Sexual Function or Body  
Image  
Dissatisfied with Appearance of  
Breast  
Vaginal Dryness  
Breast are too Large  
Breast are too Small



**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

Patient Name	Date of Birth	
Address:		
Telephone:	Social Security #:	
<input type="checkbox"/> I hereby authorize Griffin Faculty Physicians to <b>RELEASE</b> medical information TO: (Initial in box to give us permission to share your medical information with another provider, family member, insurance provider)	<input type="checkbox"/> I hereby authorize Griffin Faculty Physicians to <b>OBTAIN</b> medical information FROM: (Initial in box to give us permission to get your medical information from another provider, ie. A previous doctor)	
<b>SPECIFIC INFORMATION TO BE RELEASED</b>		
Discharge Summary:	Laboratory Reports:	ER Records:
Operative Reports:	Radiology Reports:	PT Records:
Consultation Reports:	Pathology Reports:	Other:
<b>PURPOSE OF DISCLOSURE/USE OF MEDICAL INFORMATION</b>		
<b>HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA)</b>		
<p>I understand that if the person or entity I designate to receive information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations. (If applicable) I understand that the person I am authorizing to use/disclose information may receive compensation for doing so. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any of any information in writing at any time except to the extent that action has been taken by Griffin Hospital in reliance on this authorization. Request Revocation date: _____ Intl: _____</p> <p>If not previously revoked, this consent will terminate within 90 days from the date of signature.</p>		
Patient/ Authorized Person's Signature:	Date:	
If the patient has not signed the form, please specify the signer's relationship to the patient and explain why the patient did not sign		



**AUTHORIZATION TO OBTAIN MEDICATION HISTORY INFORMATION**

Patient Name		Date of Birth
Address:		
Telephone:		Social Security #:
Please Initial in ONE of the boxes to indicate you authorization:		
<input type="checkbox"/> I hereby authorize Griffin Faculty Physicians to OBTAIN my medication history electronically from my pharmacies to better facilitate my care. I understand the initial medication history download includes data from the past two years and that medication information will update periodically in the future:		
<b>OR</b>		
<input type="checkbox"/> I HEREBY do not authorize Griffin Faculty Practice to OBTAIN my medication history electronically from my pharmacies.		
<b>HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA)</b> I understand that if the person or entity I designate to receive information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations. (If applicable) I understand that the person I am authorizing to use/disclose information may receive compensation for doing so. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any of any information in writing at any time except to the extent that action has been taken by Griffin Hospital in reliance on this authorization. Request Revocation date: _____ Intl: _____ If not previously revoked, this consent will terminate within 90 days from the date of signature.		
Patient/ Authorized Person's Signature:		Date:
If the patient has not signed the form, please specify the signer's relationship to the patient and explain why the patient did not sign		

## Written Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____	Date of Birth: _____
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I, \_\_\_\_\_, hereby acknowledge that the Griffin Hospital Notice of Privacy Practices has been made available to me, I understand that if I have further questions or complaints I may contact:

Griffin Hospital Privacy Officer  
130 Division Street  
Derby, CT 06418

I also understand that I am entitled to receive updates upon request if the Griffin Faculty Practice Notice of Privacy Practices is amended or changed in a material way.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date

### TO BE COMPLETED BY COVERED ENTITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT.

On \_\_\_\_\_, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

- ( ) Patient declined to sign this Written Acknowledgement
- ( ) Patient did not understand the request to sign the Written Acknowledgement
- ( ) Other (specify) \_\_\_\_\_

\_\_\_\_\_  
Name and title of employee

\_\_\_\_\_  
Date