



Patient Information Form

Name:	Date of Birth:
Address:	Last four (4) digits of SSN:
City: State: Zip Code:	Employer: Employer Phone:
Cell Phone: Home Phone:	Address:
Email: Work Phone:	City: State: Zip Code:
Pharmacy: Pharmacy Location:	Insurance: Insurance ID #:
Emergency Contact: Emergency Contact Phone:	Primary Care Physician: PCP Phone:

Please circle any family history of cancer(s) and indicate which family member:

Breast Ovarian Uterine Colon Lung Stomach Pancreatic **Family member:** _____

Current Medications with dosage:

Current Birth Control Method: _____

Date of Last Period: _____ **Date of last Mammogram:** _____

Date of Last Bone Density: _____ **Known Allergies:** _____

Past Medical History:

Past Surgical History:

Release of Information:

I authorize my physician, health care provider and their representatives to release any information relating to an illness, injury, diagnosis, care of treatment to my insurance company, health plan, Medicare, Medicaid or third party payer or their agents, contractors, subcontractors or affiliates provided they agree such information is kept confidential. Such information shall include, but is not limited to any medical records and medical information, including: psychiatric, psychological, nervous/mental, substance abuse (e.g. alcohol and drug abuse) and HIV and HIV-related information. I understand that the reason for furnishing such information may include the following: for use in medical, financial or provider auditing, or such other auditing as may be legally required, for utilization and/or quality of care review and assessment and for determining available health benefits and coverage.

Patient/Parent Signature _____ **Date** _____



CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH OPERATIONS

Name: _____

Birthdate: _____ SSN: _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals

I understand that I have the right:

- To object to the use of my health information for directory purposes
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restriction requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Patient or Legal Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____



Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of the ASIS MEDICAL ASSOCIATES Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restriction(s), if any, concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Regulations pertaining to medical assignment benefits apply.

Name (printed): _____ **Date of Birth:** _____

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient:

Relationship: _____ **Witness:** _____

FOR INTERNAL USE:

If patient or representative refuses to sign Acknowledgment of Receipt of Privacy Notice, document below:

Presented (date and time): _____

By (name and title): _____



Obstetrics and Gynecology

RE: Insurance Benefits

Dear Patient:

Welcome to Asis Medical Associates. We will do our best to help you with the insurance process, but we need your help. It is imperative that you keep us informed of any changes in your coverage so that we may work with your insurance company to get the best coverage possible. **Please be informed that we do not participate with HUSKY or any state funded insurance plans.**

As the insured, you are responsible to know what your insurance plan covers and you will be responsible to pay for any charges or balances not covered by your insurance company.

Please sign below in agreement of these terms and return to our office staff. Thank you.

Patient Name (print): _____ Date of Birth _____

Patient Signature: _____ Date: _____

1435 Chapel Street New Haven, CT 06511 203-562-6741

2679 Whitney Avenue Hamden, CT 06518 203-281-1181