Hartford HealthCare

Ayer Neuroscience Institute

PATIENT INFORMATION (PLEASE PRINT)

Patient Name: _____ **Date of Birth:** ____/____/_____ **SS#** _____

Address: _____ **Home Phone:** (____) _____

City: _____ **State** _____ **ZIP** _____ **Work Phone:** (____) _____

Email address: _____

Legal sex: ☐ Female ☐ Male **Sex assigned at birth:** ☐ Female ☐ Male ☐ Intersex

Patient's Pronounce: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Other _____

Gender identity: ☐ Asexual ☐ Female ☐ Gender Fluid ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Queer ☐ Other _____

Sexual orientation: ☐ Bisexual ☐ Heterosexual ☐ Homosexual ☐ Pansexual ☐ Questioning ☐ Other _____

Marital Status: Married_____ Single_____ Divorced_____ Widowed_____ Veteran: Yes_____ No_____

Employment Status: Employed_____ Not Employed_____ Retired_____ Active Military_____ Student _____

Preferred Language: _____ **Need Interpreter** Yes_____ No_____

Race: ☐ American Indian ☐ Alaskan Native ☐Asian Black/African ☐ Native Hawaiian or other Pacific Islander ☐ White/Caucasian ☐ Unknown

Ethnicity: ☐ Hispanic/ Latino ☐ Not Hispanic/ Latino ☐ Prefer not to state

Employer: _____ **Address:** _____

Primary Care Physician: _____ **Phone Number:** (____) _____

Pharmacy: _____ **Town:** _____ **Phone Number:** (____)_____

INSURANCE INFORMATION:

Primary Insurance:

Name of Insurance Co._____

ID#:_____

Group # _____

Subscriber_____

SS#: _____DOB: _____

Relationship to Insured: Self____ Spouse____Child____ Other___

Secondary Insurance:

Name of Insurance Co. _____

ID#: _____

Group # _____

Subscriber _____

SS#: _____DOB: _____

Relationship to Insured: Self____ Spouse _____Child ____Other_____

NO SHOWS AND CANCELLATIONS

Because the time we have allotted for you with the doctor is valuable, we ask that you please allow our office a minimum of 24 hours' notice if you must cancel or reschedule your appointment. Please understand that in our specialty we have a long wait list, and a last minute cancellation does not allow us enough time to schedule an additional appointment. After three "no shows" you will be discharged from the practice.

CONTROLLED DRUG POLICY

Effective January 2009, we would like you to be aware of our office policy. Under no circumstance will we prescribe or continue a prescription of Schedule II/III controlled drugs. For example: Vicodin, Percocet

I have read and understand the No Show/Cancellation and Controlled Drug Policies (Please sign below):

_____

Patients Signature Date

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:** _____

Hartford HealthCare
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Patient Information Form

Date:_____

Name:_____

DOB:_____

Medical History

Briefly describe the problem that brings you to the doctor:_____

_____

List all medical issues you currently have or have had in the past:

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

List all surgeries and procedures you have had in your lifetime:

1._____ 3._____ 5._____

2._____ 4._____ 6._____

List *ALL* current medications (Include dosage, frequency, and any non-prescription over the counter medications taken regularly):

1._____ 5._____ 9._____

2._____ 6._____ 10._____

3._____ 7._____ 11._____

4._____ 8._____ 12._____

List any medication ALLERGIES and the reactions (ex: Penicillin-Hives):_____

_____

Family Medical History	(Circle One)			**Disease or cause of Death**
1. Father	Age____	Living	Deceased	_____
2. Mother	Age____	Living	Deceased	_____
3. Bro/Sis	Age____	Living	Deceased	_____
4. Bro/Sis	Age____	Living	Deceased	_____
5. Bro/Sis	Age____	Living	Deceased	_____
6. Bro/Sis	Age____	Living	Deceased	_____
7. Child	Age____	Living	Deceased	_____
8. Child	Age____	Living	Deceased	_____
9. Child	Age____	Living	Deceased	_____
10. Child	Age____	Living	Deceased	_____
11. Child	Age____	Living	Deceased	_____

Social History *(Circle One)*

Single Married

Divorced Widowed

Occupation: _____

Do you or have you ever:

Use(d) recreational drugs Yes No

If yes, what?_____

How much/frequency_____

Used tobacco Yes No

If yes, how much? _____

If quit, when? _____

Drink alcohol? Yes No

If yes, how much/frequency?_____

If quit, when? _____

Has it ever been a problem? Yes No

PATIENT INFORMATION FORM

HHC MEDICAL GROUP NEUROSCIENCE CENTER DATE:_____

Name: _____ DOB:_____

Have any of the following symptoms been an issue for you (please circle all that apply):

CONSTITUTIONAL:
Yes / No Weight Loss
Yes / No Fatigue
Yes / No Fever
Yes / No Chills

RESPIRATORY:
Yes / No Cough
Yes / No Wheezing
Yes / No Shortness of Breath
Yes / No COPD/Emphysema

HEMATOLOGY/LYMPH:
Yes / No Easy Bruising
Yes / No Enlarged Glands
Yes / No Bleed Easily
Yes / No Blood Clots

EYES:
Yes / No Glasses/Contacts
Yes / No Eye Pain
Yes / No Double Vision
Yes / No Cataracts
Yes / No Loss of Vision

MUSKULOSKELETAL:
Yes / No Joint Pain/Swelling
Yes / No Stiffness
Yes / No Muscle Pain
Yes / No Neck pain
Yes / No Back Pain

GASTROINTESTINAL:
Yes / No Heartburn/Reflux
Yes / No Nausea/Vomiting
Yes / No Constipation
Yes / No Diarrhea
Yes / No Black or Bloody Stools

EAR, NOSE, THROAT:
Yes / No Difficulty Hearing
Yes / No Ringing in Ears
Yes / No Vertigo
Yes / No Sinus Problems
Yes / No Nasal Stuffiness
Yes / No Frequent Sore Throat

PSYCHIATRIC:
Yes / No Anxiety
Yes / No Depression
Yes / No Difficulty Sleeping
Yes / No Hallucinations
Yes / No Panic Attacks

NEUROLOGICAL:
Yes / No Headaches
Yes / No Speech Difficulty
Yes / No Imbalance/Falls
Yes / No Trouble Concentrating
Yes / No Memory Loss
Yes / No Excessive Sleepiness
Yes / No Snoring
Yes / No Weakness
Yes / No Numbness/Tingling
Yes / No Significant Head Injury
Yes / No Tremors
Yes / No Seizure/Convulsion
Yes / No Stroke/ TIA

URINARY:
Yes / No Burning
Yes / No Frequency
Yes / No Incontinence
Yes / No Frequent Infections

CARDIOVASCULAR:
Yes / No Murmur
Yes / No Chest Pain
Yes / No Palpitation
Yes / No Fainting Spells
Yes / No Heart Disease

ENDOCRINE:
Yes / No Loss of Hair
Yes / No Heat/Cold Intolerance
Yes / No Sweating
Yes / No Diabetes

SKIN:
Yes / No Rash
Yes / No Sores/Lesions
Yes / No Jaundice
Yes / No Itching

ALLERGY/IMMUNOLOGIC:
Yes / No Asthma
Yes / No Hives/Eczema
Yes / No Hay fever/Seasonal Allergies
Yes / No Tick Bites/Lyme Disease

REPRODUCTIVE: Yes / No Erectile Dysfunction Yes / No Regular Periods?

Age Onset Menstrual Periods:_____ Number of Pregnancies:_____ Age Onset Menopause_____

PROVIDER REVIEWED_____