NEW HAVEN RHEUMATOLOGY, P.C.

60 TEMPLE STREET SUITE 6A NEW HAVEN, CT 06510
PHONE (203) 789-2255 FAX (203) 495-1888

DEMOGRAPHICS

NAME: _____ SS#: _____
(LAST) (FIRST) (MI)

ADDRESS: _____
(STREET) (TOWN) (STATE) (ZIP CODE)

TELEPHONE: (HOME) _____ (WORK) _____

(CELL) _____ SEX: M__ F__ BIRTHDATE: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Marital Status: M__ S__ D__ W__ Spouse Name: _____

EMPLOYER: _____ ADDRESS: _____

EMERGENCY CONTACT NAME: _____

PHONE: _____ RELATIONSHIP: _____

INSURANCE INFORMATION

Primary: _____ ID: _____ Group: _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Secondary: _____ ID: _____ Group: _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Prescription Coverage: _____ ID: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I, _____, have received a copy of New Haven Rheumatology, PC's Notice of Privacy Policies.

OBTAINING MEDICAL RECORDS

In order to provide optimal care, New Haven Rheumatology, PC may need to obtain medical records from previous providers.

I, _____, agree to allow New Haven Rheumatology, PC to obtain my medical records.

PATIENT OR GUARDIAN SIGNATURE

I authorize New Haven Rheumatology, PC to submit insurance claims on my behalf. I also take responsibility for any legal costs that may incur with the collections of any balances.

SIGNED: _____ DATE: _____

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Meaningful Use Form

Patient's Full Legal Name: _____ **Date of Birth:** _____

We are now required to collect Race, Ethnicity and Language. If you prefer not to report that information, you may choose 'Refused to Report/Unreported.'

(Please check ONE in EACH CATEGORY that applies.)

PREFERRED LANGUAGE	RACE	ETHNICITY
☐ English	☐ American Indian	☐ Hispanic or Latino
☐ Chinese	☐ Asian	☐ Not Hispanic or Latino
☐ French	☐ Black	☐ Unknown
☐ Italian	☐ Native Hawaiian	☐ Refused to Report/Unreported
☐ Spanish	☐ Type Unknown	
☐ Other : _____	☐ White	
☐ Refused to Report/Unreported	☐ Refused to Report/Unreported	

Surescripts Consent

I, _____, agree that New Haven Rheumatology, PC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes for the duration of two (2) years.

_____ _____
Signature of Patient, Guardian or Legal Representative Date

Preferred Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____ City: _____ Zip code: _____

Pharmacy Phone: _____

Smoker Status

☐ Current every day smoker ☐ Current some day smoker ☐ Smoker, current status unknown
☐ Never a smoker ☐ Former smoker ☐ Unknown if ever smoked

Have you had your flu vaccine this season? (Sept-March) (circle one):	YES	NO
Have you had your pneumonia vaccine this year? (circle one):	YES	NO

_____ _____
Signature of Patient, Guardian, or Legal Representative Date

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Date: _____

Patient's Name: _____ Date of Birth: _____

Primary Care Physician: _____

Please list any allergies: ☐ **Latex Allergy** ☐ **NO KNOWN ALLERGIES**

Medication	**Reaction**	**Medication**	**Reaction**
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATION LIST

☐ NO ACTIVE MEDICATIONS

DATE	MEDICATION	STRENGTH/DOSE	FRENQUENCY	PRESCRIBING M.D.

Please list all vitamins and over the counter medications you are currently taking. ☐ **NONE**

_____ _____ _____

_____ _____ _____

IT IS EXTREMELY IMPORTAN THAT YOU REMEMBER TO BRING THIS LIST WITH YOU TO YOUR APPOINTMENT. THANK YOU!