PATIENT INFORMATION

Name:_____

Address:_____

_____

Phone:_____Work:_____

Date of Birth:_____

Employer:_____

INSURANCE INFORMATION

Responsible Party:_____

Relationship:_____

Primary Insurance:_____

ID Number:_____

Secondary Insurance:_____

ID Number:_____

Emergency Contact:_____

Emergency Contact Phone:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES(HIPPA)
I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Policy. I further acknowledge that a current copy of this document will be posted in the reception area, and that I may request a copy of any amendments at each appointment.

Signed:_____ Date:_____

ASSIGNMENT AND RELEASE OF INSURANCE INFORMATION/SELF-REFERRAL
I certify that I or my dependent have insurance with the above mentioned insurance company or companies and assign directly to David A. Schwindt, MD all insurance benefits for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I acknowledge that I am responsible to notify David A. Schwindt, MD of any changes in my insurance or address. I understand that I may be seeking specialty care with out a referral, and that I am responsible for applicable copayments and deductibles or the total cost of the services I receive according to the terms of my coverage.

Signed:_____ Date:_____

MEDICARE AUTHORIZATION
I request that payment of authorized Medicare Benefits be made on my behalf to David A. Schwindt, MD for any services provided. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine benefits or the benefits payable for related services. I understand that Medicare may deny payment for services if I have exceeded its published annual coverage limits for specific services, and that I am responsible for paying any balances in such instances.

Signed:_____ Date:_____

RELEASE OF MEDICAL RECORDS TO:
David A. Schwindt, MD 23 Clara Drive Mystic, CT 06355 (860)572-0010
Fax (860)536-2799

NAME:_____ DOB:_____

ADDRESS:_____

I, the undersigned, hereby request and give permission to:

_____

(Name of Person or Agency releasing information)

_____

(Address)

For the release of medical information from the treatment period of:

_____

To:

David A. Schwindt, MD
23 Clara Drive
Mystic, CT 06355
Phone: (860)572-0010
Fax: (860)536-2799

This information is needed for the following purpose:

_____

The specific information to be disclosed:

___All Records ___ER Records ___Physical Therapy ___EKG Reports

___Lab Reports ___X-Ray Reports ___Other Radiology Reports

___Operative Reports:_____

___History & Physical ___Discharge Summary

___Other:_____

If my initials appear here___, I specifically authorize release of drug/alcohol, &/or psychiatric records.
If my initials appear here___, I specifically authorize release of HIV/AIDS information.

This information disclosed is CONFIDENTIAL and is protected by state and federal laws which prohibit any further disclosure of this information unless further disclosure is permitted by written consent of the person whom it pertains to or as otherwise permitted by the regulations as stated.
I understand this consent can be revoked by me at any time upon written request (not retroactively), and this authorization will expire 90 days from the date shown below unless revoked earlier.

_____ _____ _____
Date Patient Signature Witness

PATIENT INTAKE FORM

Name: Phone: Work:
Address: Email:
Date of Birth: SSN:

How did you hear about our practice?

What Medical Problems have you been diagnosed with?

Any Previous Surgeries? Have you ever been hospitalized?
(If yes, please list year of hospitalization and what condition warranted hospitalization &/or list year surgery was performed)

Allergies: Do you have any adverse reactions to medications? (Please List)

Medications: What medications do you currently take?
(Please include prescriptions, over-the-counter, vitamins and herbal products)

Name	Dose	How Often

Do you use nutritional products/herbal medicine? If so, please elaborate, in detail, on back of this page….

Immunizations: Are your immunizations up to date? _____Yes _____No
Last Tetanus_____ Flu Shot_____ Pneumonia Shot_____

PATIENT INTAKE FORM - PAGE 2 of 3

Do you smoke tobacco: Cigarettes/day:
Have you quit (if so when)?

What is your alcohol consumption like (i.e., drinks per week)?

Any other drug use (this is a confidential form)?
What kind of work do you do?
With whom do you live?
Any pets or birds?
Any history of asbestos exposure (including working with brakes, rebuilding ships)?
(If yes, did you wear appropriate protection?)
What parts of the country have you lived in?
Have you gone on foreign travel for an extended time? If so, where?

FAMILY HISTORY

	Still Alive?	Age	Health Problems
Mother			
Father			
Sibling(s)			

Do these diseases run in your family(if so, please identify relationship):
Early Heart attack(males<55, Females<65)?
High Blood Pressure?
Diabetes?
Breast Cancer?
Colon Cancer?
Prostate Cancer?
Thyroid Disease?
Other Cancer?
Glaucoma?
Mental Health Issues?

FEMALES ONLY:
How old were you when you first started menstruating? Are you still mestruating?
Are your cycles regular? How many days of flow?
Date of first day of flow on last menstrual period? Do you pass clots?

Any previous pregnancies?
Any miscarriages?
Elective Abortions?
Living Children(please list current age and child's gender)

PATIENT INTAKE FORM – PAGE 3 of 3

REVIEW OF SYSTEMS

Do you currently have any problems with (if yes, please describe):

Night Sweats? Run Hot or Cold?
Recent, unexplained weight loss?
Vision changes?
Dry eyes?
Swollen Lymph Nodes?
Dental Cavities?
Mouth Ulcers?
Sore Throat? Hurts to swallow?
Chest Pain/Pressure?
Palpitations (aware of heart racing in chest)?
Pain in legs with walking?
Shortness of Breath (SOB)?
SOB when exerting yourself?
Nausea/Vomiting?
Loss of appetite?
Change in stools?
Painful urination?
Difficulty initiating urination?
Getting up at night to urinate?(if so, how often)
Increased frequency of urination?
Blood in urine?
Vaginal/Penile discharge?
Change in sexual desire(libido)?
Ability to reach sexual climax?
Have you recently felt depressed?
Any previous psychiatric hospitalization?
Loss of sensation?
Muscle aches?
Hip Pain?
Neck Pain?
Low Back Pain/sciatica?
Leg/arm/wrist/foot pain? Which joint?
Other joint pain?

Other Rheumatic Problems?
Other Complaints?

Headache?
Sinus Headache?
Migraines?
Runny Nose? Nasal congestion?
Nose Bleeds?
Seasonal Allergies?
Bleeding Gums?
Difficulty Swallowing?
Difficulty lying flat in bed?
Bilateral swelling in feet?
One leg more swollen than other?
Cough (&/or blood)?
Wheezing?
Vomiting: Blood? Bile?
Abdominal Pain?
Yellow skin or eyes?
Sexually transmitted infections?
Kidney stones?
Pain when having sex?
Ability to obtain/maintain an erection?
Pain with ejaculation? Blood?
Nipple discharge?
Breast changes?
Any problems sleeping?
Ever attempted suicide?
New, one-sided weakness?
Change in sensation?
New tremor?
Problems with balance?
Problems with memory?
Easy bleeding?
Easy bruising?
Heavy Periods?
Skin changes?