Collins Surgical Associates P.C., 300 Hebron Ave., Suite 211, Glastonbury, CT 06033

Patient Registration Form

Today's Date: _____Patient Name: _____DOB: _____Sex: M__ F__Other__

Street _____Apt_____

City_____State_____Zip_____

Cell # _____Home # _____Work #_____

Email Address_____ Social Security #_____

May we leave you a detailed message re: your medical care: YES NO

With whom do you allow us to share your personal medical information?

Name _____ Relationship_____ Phone _____

Name _____ Relationship_____ Phone_____

Primary Care MD _____Referring MD_____

Referral required from your insurance? YES NO

Did you contact your PCP for a referral? YES NO

Emergency Contact Name _____Relationship_____Phone_____

PLEASE BRING YOUR CURRENT INSURANCE CARD(S) TO YOUR APPOINTMENT

Primary Insurance_____

ID #_____**Group #**_____

Subscriber_____**DOB**_____**Realtionship**_____

Secondary Insurance_____

ID #_____**Group #**_____

Subscriber:_____**DOB**_____**Relationship**_____

Subscriber: the person whose employment makes him or her eligible for group health insurance benefits. In order for the insurance to process your claim we need the name of the subscriber as it is spelled on the insurance form, their Date of Birth, and their relationship to the patient. Even if we have scanned your card into the system, you must list the order in which your insurances are to be billed.

Name _____**DOB**_____**Date**_____

Medical History: Please circle any past or present medical issues

High blood pressure Diabetes High cholesterol Heart attack Atrial fibrillation Stroke
Vascular disease Peptic ulcer GERD Diverticulitis Crohn's disease or UC IBS
Hepatitis/Liver disease Pancreatitis Asthma COPD Sleep apnea Kidney disease Anemia
HIV/AIDS Alcoholism Drug abuse Bleeding disorder DVT/PE (blood clot) Osteoporosis
Rheumatoid arthritis Osteoarthritis Lupus Anxiety/Depression Bipolar disorder Schizophrenia
Parkinson's Dementia Thyroid disorder Seizures Other (please specify)_____
Cancer: YES NO
Type:_____
Prior Colonoscopy? Date/results:_____ Prior Mammogram? Date/results_____

Surgical History: Please list prior operations and approximate dates performed.

_____
_____
_____

Prescription medications (or attach list):

_____
_____
_____
_____
_____

Allergies:_____**Height:**_____**Weight:**_____

Social History: Do you smoke? _____Ever Smoke? _____ Packs/day?_____
Alcohol? _____ Drinks per day? _____
Drug Use? _____ Past drug use? _____

Name _____**DOB**_____**Date**_____

Family History: Check all that apply or write in relatives as needed.

Disorder	Mother	Father	Sister/Brother	Other
Colon Cancer				
Breast Cancer				
Ovarian Cancer				
Prostate Cancer				
Melanoma				
Thyroid Cancer				
Lymphoma/Leukemia				
Other cancer				
Heart disease				
Stroke				
COPD/Emphysema				
Diabetes				
Kidney Disease				
Anemia				
Blood clotting disorder				
Crohn's/Ulcerative colitis				
Other				

Review of systems: Please circle any and all of the symptoms that apply to you.

General: fevers/chills night sweats unexplained weight loss loss of appetite

Heart: chest pain/tightness palpitations waking up short of breath inability to lay flat

Resp: difficulty breathing wheezing persistent cough

GI: nausea vomiting difficulty swallowing jaundice change in the bowel habits rectal bleeding

GU: painful urination urinary urgency or frequency blood in urine

Skin/Breast: changes in mole/wart sore that won't heal unusual lumps

Heme/Lymph: unusual bleeding easy bruising ankle or leg swelling

If you have any imaging that pertains to your visit (CT scan, ultrasound, mammogram, MRI) please bring the actual images in with you for the appointment. This is easily accomplished by calling the radiology location where you had the study done and asking them to put the images on a disc for you.

Note: If you had your imaging done through Radiology Associates of Hartford (RAH), you do not have to obtain those images as Dr. Tandon can review them digitally.

Name _____DOB_____Date_____

Collins Surgical Associates P.C.

PRIVACY RULE (HIPPA) PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. I understand that I have certain rights to privacy regarding my protected health information. When it is appropriate and necessary, I understand that the minimum necessary information about treatment, payment or health care operations will be provided in order to provide health care that is in my best interest.

I have been informed by you and/or your representative of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I may refuse to consent to the use or disclosure of my personal health information, but this must be in writing. Under this law you have the right to refuse to treat me should I refuse to allow disclosure of my Personal Health Information (PHI), I understand that I may revoke this consent in writing at any time except to the extent of actions that have already been taken which relied on this or previously signed consent.

I _____ have received/reviewed a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____

SIGNATURE ON FILE

I authorize the release of any medical information to my insurance carrier as requested by them. I permit a copy of this authorization to be used in place of the original.

Signature _____Date_____