HARTFORD NEUROLOGY, LLC
NEW PATIENT REGISTRATION

Name_____Home Telephone (____) _____

Date of Birth_____ Age_____ Social Security # _____Cell # (____)_____

Address_____ City/State/Zip_____

Employer_____Occupation_____

Address_____Telephone_____

Spouse/Guardian/Other_____Occupation_____

Employer_____Telephone_____

Address_____

Work Related Injury? Yes _____ No _____ Auto **Accident Injury?** Yes _____No _____

***If answered yes, is there an existing claim?** ____ Yes _____ No

INSURANCE/BILLING INFORMATION
(Please note: if a referral is required; it is your responsibility to make sure you have a referral in place before the appointment)

Primary Insurance Company_____

Name of Insured _____D.O.B._____ Insured SS# _____

Relationship to_____ ID#_____ Group# _____ Co pay _____

Secondary Insurance Company_____

Name of Insured _____D.O.B._____ Insured SS# _____

Relationship to_____ ID# _____ Group # _____ Co pay _____

Tertiary Insurance Company_____

Name of Insured _____D.O.B._____ Insured SS# _____

Relationship to_____ ID# _____ Group # _____ Co pay _____

MEDICAL INFORMATION

Referring Physician_____ Referring Dr. Phone Number_____

Address_____

Primary Care Physician (PCP)_____ PCP Phone Number_____
(If different from above)

Address_____

Pharmacy_____
ADDRESS & TOWN

Have you ever seen a neurologist in the past? _____ If yes, who/where? _____

I hereby authorize the release of medical information and/or payment directly to Hartford Neurology, LLC.

Signature_____Today's Date_____

DOB:

HARTFORD NEUROLOGY, LLC
Patient Questionnaire Form

Patient: _____ Date: _____

History:

Chief Complaint: _____

History of Present Illness:

*Location: _____ *Quality: _____

*Severity: _____ *Duration: _____

*Timing: _____ *Modifying factors: _____

*Associated symptoms: _____

MEDICAL HISTORY:

***Past medical history**

Diabetes……	No	Yes
Hypertension……..……....	No	Yes
Cancer……...	No	Yes
Stroke……	No	Yes
Heart trouble…….	No	Yes
Arthritis/gout……	No	Yes
Convulsions……......	No	Yes
Bleeding tendency…….	No	Yes
Acute infections…….	No	Yes
Venereal disease……	No	Yes
Hereditary defects…….	No	Yes

HEALTH MAINTENANCE

Have you had a Mammogram? Yes No
If so, when? _____

Have you had a Colonoscopy? Yes No
If so, when? _____
Flu Vaccine: YES Date: _____ NO
Pneumonia Vaccine: YES Date: _____ NO
Eye Exam: YES Date: _____ NO
Dilated? YES NO
Normal? YES NO

Other Past Medical History: _____

_____

_____

Patient Social History:

Marital status: Single___ Married___ Separated___ Divorced___ Widowed___
Use of alcohol: Never: ___ Occasional: ___ Moderate: ___ Daily: ___
Use of tobacco: Never: ___ Previously, but quit: ___ Current packs/day: ____
Use of recreational drugs: Never: ___ Type/frequency: _____
Excessive exposure at work from: Fumes: ___ Dust: ___ Solvents: ___ Air-borne particles___

Patient Family History:

	Age	Diseases	If deceased, Cause of Death
Father	___	_____	_____
Mother	___	_____	_____
Sibling	___	_____	_____

Have you ever had:

CAT or MRI scan	No	Yes: when and where? _____
EMG	No	Yes: when and where? _____
EEG	No	Yes: when and where? _____
Spinal tap	No	Yes: when and where? _____

HARTFORD NEUROLOGY, LLC
Patient Questionnaire Form

Patient Name: _____ Date:_____

Date of Birth: _____ Age: _____ Current Weight: _____Height: _____

SYSTEM REVIEW

Check off symptoms that apply to you

CONSTITUTIONAL SYMPTOMS
- Recent weight changes ☐
- Fever ☐
- Fatigue ☐

EYES
- Visual loss ☐
- Glaucoma ☐

EARS/NOSE/MOUTH/THROAT
- Hearing loss ☐
- Ringing in the ears ☐

CARDIOVASCULAR
- Heart trouble ☐
- Lightheaded or dizziness ☐
- Chest pain or angina ☐
- Palpitations ☐
- Swelling in the feet or ankles ☐

RESPIRATORY
- Chronic or frequent cough ☐
- Spitting up blood ☐
- Shortness of breath ☐
- Asthma or wheezing ☐
- COPD ☐
- Sleep Apnea ☐

GASTROINTESTINAL
- Rectal bleeding or blood in stool ☐
- Abdominal pain or heartburn ☐
- Peptic ulcer disease ☐

GENITOURINARY
- Painful urination ☐
- Frequent urination ☐
- Change in force of stream when urinating ☐
- Incontinence or dribbling ☐
- Nephrolithiasis (kidney stones) ☐
- Hematuria (blood in urine) ☐
- Recurrent Urinary Tract Infection ☐

MUSCULOSKELETAL
- Joint pain or swelling ☐
- Muscle Weakness ☐
- Muscle pain or cramps ☐
- Low Back pain ☐
- Neck Pain ☐

INTEGUMENTARY/SKIN and BREAST
- Rash or itching ☐

NEUROLOGICAL
- Frequent or recurring headaches ☐
- Convulsions or seizures ☐
- Numbness or tingling sensations ☐
- Tremors ☐
- Paralysis ☐
- Stroke ☐
- Head injury ☐
- Difficulty walking ☐
- Memory loss ☐
- Daytime sleepiness ☐

PSYCHIATRIC
- Depression ☐
- Anxiety ☐

ENDOCRINE
- Thyroid disease ☐
- Diabetes ☐

HEMATOLOGICAL/LYMPHATIC
- Anemia ☐
- Past blood transfusion ☐

Allergies? _____

_____

_____

MEDICATION LIST: ***if you have a list, we can attach a copy for your convenience***

Medication Name & MG (or MCG / ML)	Dosage (# of pills taken)	Frequency (how often taken)

HARTFORD NEUROLOGY, LLC DOB:
PRIVACY NOTICE

As a patient of Hartford Neurology, LLC, we want to provide you with the best possible care. We want you to feel free to make full disclosure of information to the physician(s) so that effective treatment can be provided. As required by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Hartford Neurology, LLC is providing you, the patient or the patient's legal representative, with a copy of our Privacy Notice. HIPAA regulations require us to provide this information to you and to obtain your signature or the signature of your legal representative as proof that you have received our Privacy Notice.

The policy of Hartford Neurology, LLC is to protect the confidentiality, integrity, and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use of such information. This policy applies to both current and former patients.

Protected Health Information (PHI) is individually identifiable health and personal information and includes any information obtained by Hartford Neurology, LLC in connection with providing healthcare treatment, obtaining payment and related healthcare operations. This relates to past, present or future information that Hartford Neurology, LLC receives from you as our patient.

We will use this information to provide caring and quality medical care to you. Examples of PHI include diagnosis, treatment, and communications, both oral and written and including answering machines, voice mail and e-mail, used for follow-up, appointment scheduling, reminders, and test results reporting. As part of our standard healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to coordinate your treatment plan in the most efficient manner. For insurance carriers, your information will be used for claims submission and to obtain payment for services provided. We will exchange data with your insurance carrier for activities such as confirming your eligibility with the plan, benefit and coverage determinations, and pre-certification/authorization and utilization review.

Your information is maintained in our office in our practice management information system. We also maintain information about you in your medical chart. Hartford Neurology, LLC limits access to your PHI to those employees and business associates who need to know this information and we restrict the types and amount of information provided to that which is "minimally necessary" in order to carry out their work.

We do not disclose PHI to third parties for purposes other than treatment, payment or health care operations unless the following exceptions occur:

- We receive a signed authorization from you to release your individually identifiable information. Hartford Neurology, LLC will provide you with an Authorization Form that will need to be signed by you, the patient, or in the case of a minor, his/her guardian. This authorization will be for a defined period of time and may be cancelled by you, the patient, or in the case of a minor, by his/her guardian, at any time.
- Federal, state or other applicable law requires us to share PHI.
- Workers' Compensation purposes.

You have the right to request a review of your PHI, to amend your records, and request restrictions on how your PHI is used. You may request an accounting of how your PHI has been disclosed. Any requests for amendments or restrictions to the use of your PHI must be in writing. You have a right to request a copy of your medical record. Hartford Neurology, LLC will make every effort to provide you with your record within a reasonable amount of time and subject to normal copying charges. If you have any questions, comments or complaints regarding the management of your PHI, please contact the office at (860) 522-4429.

I acknowledge that I have received the above Hartford Neurology, LLC Privacy Notice.

_____ _____

✓**Patient Name** ✓**Date**

HARTFORD NEUROLOGY, LLC DOB:

CONSENT FOR TREATMENT AND RELEASE INFORMATION

I AUTHORIZE to **HARTFORD NEUROLOGY, LLC'S** use & disclosure of all individual identifiable personal, health, financial, & demographic information (known as Protected Health Information or PHI) for the purpose of:

- Providing medical treatment
- Obtaining payment & reimbursement
- Obtaining authorizations from my insurance for test (where required)
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical care
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me

The above purpose & all other uses are known collectively as Treatment, Payment, & Other healthcare options or TPO.

I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to **HARTFORD NEUROLOGY**, **LLC**, when needed for the purpose of TPO.

I CONSENT to HARTFORD NEUROLOGY, LLC discussing any or all my medical care including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, acquired immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following person(s).

1. **_____Relationship: _____**
2. **_____Relationship: _____**
3. **_____Relationship: _____**
4. **_____Relationship: _____**

I CONSENT to HARTFORD NEUROLOGY, LLC leaving messages on my answering machine.

I have been given the opportunity to review HARTFORD NEUROLOGY, LLC's, Privacy Notice.

I understand my rights to restrict the use & discloser of PHI & to revoke this consent at any time in writing.

I understand that should I choose not to consent to the terms & conditions of HARTFORD NEUROLOGY, LLC's Privacy Notice, the practice has the right to & will withhold treatment except where required by law.

PATIENT NAME: _____

PATIENT'S SIGNATURE_____DATE: _____

INSURED OR GUARDIAN'S SIGNATURE_____ DATE: _____

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and discloser of protective health information for treatments, payments, & other healthcare operations without a signed consent & prohibits the use and discloser of protective health information for non healthcare related activities without specific & explicit authorization.