Eastern Connecticut Hematology and Oncology

330 Washington Street, Suite 220, Norwich, CT 06360
860-886-8362 Fax 860-886-9262

Patient Demographics and Registration

Date: ____________________

Name: ____ Date of Birth: ______________ ☐ Male ☐ Female
Last First MI

Social Security #: _________________ Mailing Address: ____

City: ___________________________________ State: ___________________________ Zip: ______________

Primary Phone: _________________ Secondary Phone: _________________ Work Phone: ________________

Race: ____ Ethnicity: Hispanic or Latino: ☐ Yes ☐ No ☐ Decline

Primary Language: ☐ English ☐ Spanish ☐ Other: __________________________ Marital Status: S M W D

Employer: ______________________________________ Occupation: __________________________________

Name of Emergency Contact: ____

Relationship: ____________________________________ Phone: ________________________________

Name of Emergency Contact: ____

Relationship: ____________________________________ Phone: ________________________________

Primary Insurance: ______________________________________ ID #__________________________________

Subscriber Name: ____________________________ D.O.B: ____________ Group #: _______________________

Secondary Insurance: ______________________________________ ID #________________________________

Subscriber Name: ____________________________ D.O.B: ____________ Group #: _______________________

Primary Care Physician: _______________________________________ Phone: __________________________

Referring Physician: ____ Phone: __________________________

Reminder: You must bring your insurance cards and a photo ID

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----- HIPAA Acknowledgements -----

I hereby acknowledge that a copy of the medical practice's **Notice of Privacy Practices** which explains how my medical information will be used in this office is available, and I may obtain a copy at any time. I further acknowledge that a copy of the current notice will be **posted** in the reception area.

I authorize Eastern Connecticut Hematology and Oncology to speak with any spouse, family member, caregiver, and/or friend as listed below regarding my care, biopsy results, appointments, doctor visits, etc.

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

<u>**Confirmation Calls**</u>: Our office uses *TalkSoft* to do all confirmation calls. We may use and disclose medical information to contact and remind you about appointments. If you are not at home, we may leave this information with the person answering the phone, or on your answering machine/voice mail. In accordance with the privacy protection law, I agree to the following:

Eastern Connecticut Hematology and Oncology may identify themselves and leave a detailed message when contacting me on my:

Home or Cell Phone: ____________________________
(Circle one) (list one phone number only)

- I authorize use of this form on all insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand that I am responsible for my bill and office copays.
- I authorize my doctor to act as my agent in helping me obtain payment for my insurance companies.
- I authorize payment directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.

My signature indicates that I agree to all the information above, or as it has been explained to me.

Printed Patient Name: ______________________________

Signature of Patient or Guardian: ______________________________ Date: ________________

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Authorization to Disclose/Obtain Health Information

I, the undersigned patient or legal representative, hereby authorize the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information.

Patient Name: ______________________________ Date of Birth: ______________

I authorize ______________________________ to disclose health information to:

Eastern Connecticut Hematology and Oncology by fax to: **860-886-9262** or

mail to: **330 Washington Street, Suite 220, Norwich, CT 06360**

-------- OR -------- **-------- OR --------** **-------- OR --------** **-------- OR --------** **-------- OR --------**

Eastern Connecticut Hematology and Oncology may **release** my health information to: ______________

____

The dates of service and the type(s) of information to be used or disclosed are as follows:

Date(s) of Treatment: ____

□ History & Physical □ Discharge Summary □ ED Record □ Operative Reports □ Consultations

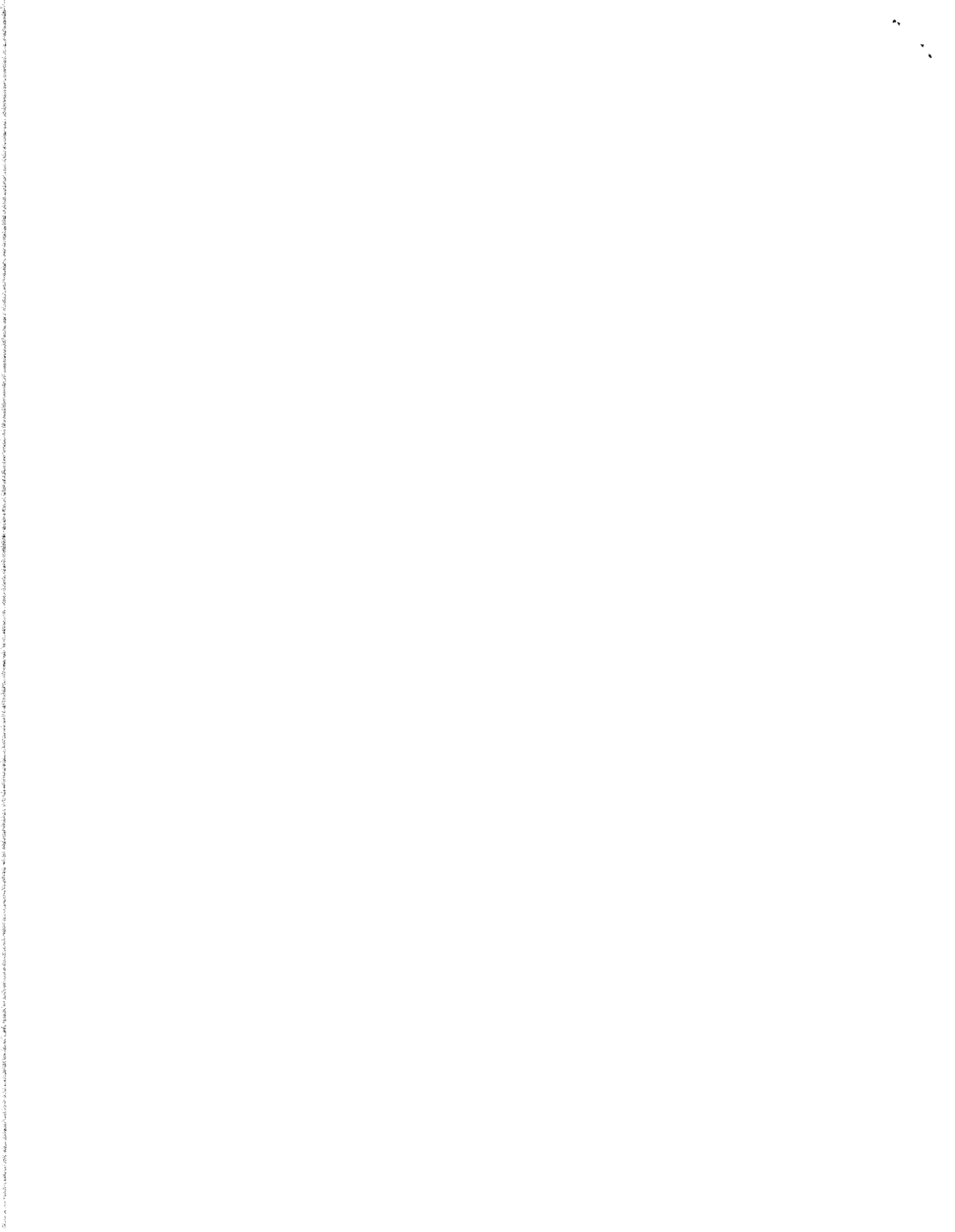
□ Laboratory Reports □ Radiology Reports □ Radiology Films □ Pathology Reports □ Progress Reports

□ Billing Records □ Entire Record □ Other ______________________________

- This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying Patient Relations in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
- I understand that my treatment or continued treatment by ECHO is in no way conditioned on whether I sign this authorization, and that I may refuse to sign it.

______________________________ ______________

Signature of Patient or Legal Representative Date



Medication List   *Please PRINT CLEARLY*

Name: ______________________________ D.O.B: ______________________

Pharmacy: ____________________________ In which Town: __________________

Mail Order Pharmacy: ____

Allergies to medications: ____

Do you have an allergy to Latex such as: Band-Aids, rubber gloves, balloons, condoms? □ Yes □ No

Other Allergies such as food or environment: ______________________________

DAILY MEDICATIONS: *List Vitamins, Herbal Supplements, NSAIDs on back of page if more room is needed*

Drug Name Generic or Brand	**Dose**	**Times Taken Per Day**	**Start Date**	**Stop Date**	**Medication is taken for:**	**Ordering Physician**
Example: Glucotrol	***5 mg***	***2 times***	***2015***		***Diabetes***	***Dr. John***

List Vitamins, Herbal Supplements, NSAIDs on back of page if more room is needed

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Drug Name Generic or Brand	Dose	Times Taken Per Day	Start Date	Stop Date	Medication is taken for:	Ordering Physician