NEW MILFORD MEDICAL GROUP

11 Old Park Lane Road
New Milford, CT 06776
Phone: 860-355-1149
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www.nmmedicalgroup.com

PRIMARY CARE
Jeffrey C. Tyler, MD
Doreen M. Konik, MD
Christian Leonardi, DO
Jonathan D. Beck, MD
Kristin C. Newton, MD
Dmitry Albin, MD

CARDIOLOGY
Michael G. Levine, MD, FACC

PHYSICIANS ASSISTANTS
Caitrin Olson, PA-C
Kara Clark, PA-C
Mae Janiga, PA-C

Patient's Name:_____
Last First Middle

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone#:_____ Cell Phone#: _____ Marital Status (circle one): S M D W

Social Security No.:_____ Date of Birth: _____ Email Address: _____

Employer:_____ Work Phone:_____

Emergency Contact: _____ **Relationship:** _____ **Phone#**_____

Race (circle one): Caucasian/White African-American Asian Hispanic Indian Multiracial Other _____

Primary Language: English Spanish Other _____ Ethnicity: Hispanic/Latino Not Hispanic/Latino

PRIMARY INSURANCE

Insurance Carrier Name: _____ ID#:_____ Group#:_____

Policyholder Name_____ DOB:_____ Soc Sec #_____

Home Address: _____ Email Address: _____

Home Phone_____ Cell Phone _____ Relationship to Patient:_____

SECONDARY INSURANCE

Insurance Carrier Name: _____ ID#:_____ Group#:_____

Policyholder Name_____ DOB:_____ Soc Sec #_____

Home Address: _____ Email Address: _____

Home Phone_____ Cell Phone _____ Relationship to Patient:_____

Pharmacy 1st Choice _____ Location _____

Pharmacy 2nd Choice_____ Location_____

I hereby authorize New Milford Medical Group to furnish all information to insurance carriers and other health care providers concerning my illness and treatments and assign all payments for medical services rendered to myself or my dependents to New Milford Medical Group, LLC. I understand that I am responsible for any amount not covered by insurance. This information includes Protected Health Information.

Signature of Patient or Authorized Person:_____

Printed Name:_____ **Date:** _____

Relationship of Authorized Person to Patient:_____

New Milford Medical Group

COMPREHENSIVE PATIENT MEDICAL HISTORY FORM

Your answers on this form will help your clinician understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details or date. Thank you!

PERSONAL INFORMATION:

Preferred Name:_____ DOB:_____ Date:_____

MEDICATIONS: (Prescription and non-prescription medications, vitamins, birth control pills, herbs and supplements.)

MEDICATION	DOSE	FREQUENCY	PRESCRIBING DOCTOR	PHARMACY #1	PHARMACY #2

Drug Allergies or Reactions to Medications / Foods / Other Agents: # Yes # No Please list:

_____

PERSONAL MEDICAL HISTORY: Do you have any of the following?

Acid Reflux (heartburn)
Alcoholism
Allergies (environmental)
Anxiety
Asthma
Atrial Fibrillation
Cancer (list below)
Cholesterol Problem
Coagulation (bleeding) Problem
Chronic Low Back Pain
Depression
Diabetes
Erectile Dysfunction
Gout
High Blood Pressure
Heart Disease (explain below)
Migraines
Osteopenia / Osteoporosis
Prostate Problems
Thyroid Problems
Other Chronic or Recurring Medical Problems (Please list below)

_____

Have you had any bloodwork in the last 6 months? # Yes #No If yes, which lab: _____

Have you consulted with any specialists in the last 6 months? #Yes #No Please list:_____

Have you had any screening and/or diagnostic radiology studies done in the last 12 months? #Yes #No

Please List type of study and facility name: _____

Patient Name:_____Date: _____

PRIOR SURGERIES AND HOSPITALIZATIONS: # Yes # No (Please list all prior operations and hospitalizations)

DATE	SURGERY OR HOSPITALIZATION	DATE	SURGERY OR HOSPITALIZATION

Have you received a blood transfusion? # Yes # No When?_____

FAMILY HISTORY: Please indicate with a check any family members who have had any of the following conditions:

Check here if you do not know your family history #_____

MEDICAL CONDITION	MOM	DAD	BRO	SIS	DAUG	SON	OTHER CLOSE RELATIVES	MEDICAL CONDITION	MOM	DAD	BRO	SIS	DAUG	SON	OTHER CLOSE RELATIVES
Alcoholism								Genetic Diseases							
Anemia								Glaucoma							
Anesthesia Problem								Allergies							
Arthritis								High Cholesterol							
Asthma								Heart Disease (Heart attack, stent or bypass surgery)							
Birth Defects								High Blood Pressure							
Cancer, Breast								Kidney Disease							
Cancer, Colon								Migraine Headaches							
Cancer, Melanoma								Osteoporosis							
Cancer, Other Skin								Rheumatoid Arthritis							
Cancer, Ovary								Seizures							
Cancer, Prostate								Strokes							
Cancer (other list below)								Thyroid Disorders							
Colon Polyps								Tuberculosis							
Depression								Other:							
Diabetes, Type 1															
Diabetes, Type 2															

Patient Name:_____Date: _____

SOCIAL HISTORY:

Tobacco Use

Please check one

I have never smoked

I have smoked, but rarely

When was the last time?_____

I have quit smoking. Quit Date:_____

How many packs/day?_____How many yrs?_____

I currently smoke_____pack(s)/day.

How many yrs._____

Other Tobacco: # pipe # cigar # snuff # chew #vape

Are you interested in quitting? # Y # N

Alcohol Use

Do you drink alcohol? # Y # N

never # occasionally # regularly

Average # drinks/week? 5 oz. wine_____

12 oz. beer_____ 1.5 oz. hard liquor_____

Is alcohol use a concern for you or others? # Y # N

Drug Use

Do you use recreational drugs? # Y # N

Have you ever used needles? # Y # N

Sexual History

Are you sexually active? # Y # N # not currently

Current sexual partner(s) is/are # male # female

Birth control method:_____

Have you ever had any sexually transmitted diseases (STD's)? # Y # N Date:_____Which STD?_____

Are you interested in being screened for sexually transmitted diseases? # Y # N

Do you exercise? # Y # N How often? # Daily # 4 – 6x a week # 1 – 3x a week # less than one time a week

Do you have a dental exam at least yearly? # Y # N Do you have an eye exam at least every two years? # Y # N

Safety

Do you use seat belts consistently? # Y # N

Is violence at home a concern for you? # Y # N

Are you currently in a relationship? # Y # N

If yes, do you feel safe in this relationship? # Y # N

other concerns?_____

Socioeconomics

Marital Status: # single # married # separated # divorced # widow

Occupation:_____

Education completed: # grade school # high school # college # graduate school

Number of children:_____Who lives at home with you?_____

Frequent foreign travel? # Y # N Where?_____

New Milford Medical Group

NO SHOW/MISSED APPOINTMENT POLICY

Appointments MUST be cancelled **before 3pm** of the previous day, or by **3pm on Friday** for a Monday appointment. You may cancel an appointment via phone call 860/355-1149, option 2 and/or via the appointment reminder sent to you prior to your appointment.

Cancelling after 3pm will be considered a "Missed Appointment". Not attending the appointment is considered a "No Show". Fees will be assessed to the patient.

MISSED APPOINTMENTS ARE NOT COVERED BY INSURANCE AND ARE YOUR RESPONSIBILITY

PLEASE REVIEW THE FOLLING FEES:

- Established Patient Annual Physical - $80
- Established Patient Office Visit - $60
- New Patient Annual Physical -$100
- New Patient Office Visit -$75
- Echo - $75
- Ultrasound - $85
- Cardiology Consult - $130
- Cardiology Office Visit - $100

Fees will be assessed to the patient for EACH "Missed or No Show" appointment. If cancelled before 3pm, no fees are assessed to the patient.

Should you be assessed with 3 or more "Missed/No Show" Appointments, your provider will consider this as a breach in your "patient to physician relationship" as well as "non-compliant with your medical care plan". This can lead to a dismissal from the practice, which you will be notified by mail if approved.

As a courtesy, appointment reminders are made multiple times to the contact information we have on file for the patient. It is the patient/guarantor's responsibility to inform the office if the contact information requires updating.

I have read and understand New Milford Medical Group's No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify New Milford Medical Group appropriately if I have difficulty keeping my scheduled appointments.

Patient Name	Date of Birth	Date

Patient Signature or Parent/Guardian (if minor)	Relationship to Patient

NEW MILFORD
MEDICAL GROUP

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received, or have been given the opportunity to receive, a copy of the New Milford Medical Group's Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

Provided By HCP

NEW MILFORD
MEDICAL GROUP

AGREEMENT FOR SHARING AND COMMUNICATION OF PHI

Patient confidentiality is a top priority at New Milford Medical Group (NMMG). Therefore, it is important that you provide us with the following information to ensure that there is no violation of your privacy.

New Milford Medical Group staff may leave messages regarding results (test/lab), scheduling (appointments and procedures) and billing information with the following (please check all that apply):

Spouse _____ Answering machine at home _____

Voice mail at work _____ Voice mail at cell phone _____

Other – Describe: _____

NMMG staff **may not** leave any information _____

Please list any family members who may obtain or call and discuss your medical information:

Name	Relationship	Phone number

I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff at New Milford Medical Group.

_____ _____
Patient Name (Print) Patient Date of Birth

_____ _____
Signature of Patient or Authorized Person Date

_____ _____
Relationship of Authorized Person to Patient Reason Patient Unable to Sign

Provided By HCP

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient or legal representative, hereby authorize New Milford Medical Group to disclose or obtain health information, *including if applicable*, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and confidential HIV related information regarding:

Patient Name **Patient DOB:** **Date:**

1) Information may be: ____ **Disclosed to** **OR** ____ **Obtained from Other Facility**

Name/Facility: _____

Mailing Address: _____

Phone#: _____

____ Hand Carry ____ CD ____ Mail ____ Fax to: _____

2) The purpose of this disclosure or use is for the following reason:

____ Medical ____ Legal ____ Consult ____Transfer of care ____ Patient/Self

3) The date(s) of service to be disclosed: _____

4) Requested Information: ____ Complete Record ____ History & Physical ____ EKG Report ____ Lab Report
____ Consultations ____ Hospital Records ____ Echo Report ____ Ultra Sound (vascular or body)
____ Billing Statement(s) Other: _____

This authorization will be valid for a period of **three years (3)** from the signature date below. Medical records will only be released for dates of service which occur prior to the authorization date unless disclosure of a future service date is specifically authorized. I understand that I may cancel this authorization at any time by notifying New Milford Medical Group in writing, but if I do, it will not have any effect on actions that the releases took before it received the cancellation. I understand that I may inspect or request a copy of the information to be used or disclosed by the recipient.

Copy Fees: I understand that New Milford Medical Group may charge a fee for copying and first class postage to the individual receiving the requested information. Copy fees will be applied in accordance with the Connecticut Statue at $.065 cents per page.

Fax or mail requests to above location. Please allow 48-72 hours for your request to be completed.

_____ _____ _____

Signature of Patient or Legal Representative **Printed Name** **Relationship to Patient** **Date**