NEW MILFORD MEDICAL GROUP

11 Old Park Lane Road
New Milford, CT 06776
Phone: 860-355-1149
Fax: 860-355-5957
www.nmmedicalgroup.com

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

CARDIOLOGY
Michael G. Levine, MD, FACC
Donald I. Katz, 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: _____ **Date:** _____

Printed Name: _____ **Relationship of Authorized Person to Patient:** _____

New Milford Medical Group

NO SHOW/MISSED APPOINTMENT POLICY

We, at New Milford Medical Group, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible. You can cancel appointments by calling the following number: 860/355-1149.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder to you is made/attempted two (2) business days prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment by 3pm of the previous day, or by 3pm on the Friday before a Monday appointment.
2. If an after 3pm cancellation is given this will be documented as a "Missed" appointment.
3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.
4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter informing that you have broken our "No-Show/Missed" policy. Our staff will assist you to reschedule this appointment if needed.
5. If you have 2 "No-Show/Missed" appointments within a **six-month timeframe**, you will be assessed a $50 "No-Show/Missed" fee.
6. If you have 3 "No-Show/Missed" appointments within a **one-year time**, you will receive a second $50 no show fee assessment. Dismissal from the practice will be considered at this time.
   ***You will be notified by letter if the dismissal was approved.**

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.

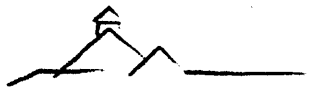
_____ _____ _____

Patient Name Date of Birth Date

_____ _____

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

MISSED APPOINTMENT CHARGES ARE NOT COVERED BY INSURANCE AND ARE YOUR RESPONSIBILITY



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

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

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?_____

Patient Name:_____Date: _____

Immunizations: Please check any immunizations you were given and your best estimate of the month and year it was given.

Tetanus: # Y # N_____Pneumonia: # Y # N_____Chicken Pox: # Y # N_____Hepatitis A: # Y # N_____

Hepatitis B: # Y # N_____HPV (genital warts): # Y # N_____Shingles: # Y # N_____

REVIEW OF SYSTEMS (please circle any *CURRENT* problems you have on the list below)

General
- Fatigue / Weakness
- Restless Sleep
- Daytime Drowsiness
- Unhappiness
- Depression / Sadness
- Feeling "Blue" or Hopeless for More than 2 wks
- Lack of Motivation
- Excessive Irritability
- Feelings of Worthlessness
- Nervous / Anxiety
- Unexplained Fever (> 100.0)
- Frequent Night Sweats
- Unexplained Weight Loss
- Unexplained Weight Gain
- Excessive Thirst

Skin
- Changes in Moles / Unusual Moles
- Concerns re: skin spots / rashes / growths
- Bruise Easily
- Itching
- Excessive Hair Growth
- Hair Loss

Ears / Nose / Throat
- Allergy Symptoms
- Hearing Loss
- Ringing in the Ears
- Dizzy Spells / Dizziness
- Nose Bleeds
- Sinus Problems
- Hoarseness – Frequent

Eyes
- Eye Pain
- Double Vision / Change in Vision
- Itchy / Watery Eyes

Lungs
- Cough / Wheeze
- Snoring / Gasping at Night During Sleep
- Difficulty Breathing
- Positive TB Skin Test

Heart
- Chest Pain / Pressure
- Recent Change in Exercise Tolerance
- Heart Murmur
- Palpitations / Irregular Pulse
- Fainting Spells
- Swollen Ankles
- Leg Pain with Walking / Exercise

Gastrointestinal
- Abdominal Pain
- Heartburn / Indigestion
- Change in Bowel Habits – Recent
- Difficulty Swallowing
- Persistent Nausea / Vomiting
- Diarrhea / Constipation
- Bloody or Black Tarry Stools
- Frequent Laxative Use? How Often?

Musculoskeletal
- Muscle / Joint Pain
- Recurrent or Chronic Back Pain
- Joint Swelling
- Gout

Genitourinary
- Frequent Urine Infections
- Painful Urination
- Frequent Urination
- Urinary Leakage / Incontinence
- Blood in Urine
- Overnight Urination > 2 x
- Sexual Function Problems

Male
- Decrease in Force of Urination
- Erection Problems
- Testicle Lumps / Swelling

Female
- Vaginal Discharge / Itching
- History of Abnormal Pap Smear
- Pain / Bleeding During Sex
- Significant Pain / Cramps with Menses
- Hot Flashes / Night Sweats

Menstrual History
- Age of onset_____reg. / irreg. / menopause
- Flow: heavy / moderate / light
- Length of cycle_____Days of flow_____
- # of pregnancies_____# ofbirths _____
- # of miscarriages / abortions_____

Breast
- Pain / Lumps / Discharge

Neurological
- Frequent Headaches
- Numbness / Tingling
- Memory Loss
- Tremor / Shaking

Explanation:_____