



Patient name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Who should be notified **in case of emergency?** \_\_\_\_\_

Relationship to you?: \_\_\_\_\_ Phone number: \_\_\_\_\_

Alternate phone number: \_\_\_\_\_

Do you have an advance directive?: \_\_\_\_\_

What is your chief complaint today? \_\_\_\_\_

**Family Medical History:**

Diabetes     Heart disease     Colon cancer     Breast cancer     Other cancer

Other \_\_\_\_\_

**Current prescription or over the counter medication, vitamins, supplements:** (please list)

**Allergies:** \_\_\_\_\_

**Current health history:** Please list any medical conditions you now have.

**Past medical history:** Please list past surgery or hospitalizations.

**Review of systems:** Are you currently having or have you had problems with:

		circle			circle
Eyes	yes	no	Asthma	yes	no
Lungs, breathing	yes	no	Blackout/fainting	yes	no
Digestion	yes	no	Ears, nose, throat	yes	no
Bowel movements	yes	no	High blood pressure	yes	no
Bladder problems	yes	no	Bleeding problems	yes	no
Anemia	yes	no	Arthritis	yes	no
Polio	yes	no	TB	yes	no
Epilepsy	yes	no	Chronic constipation	yes	no

**Social History:**

Do you exercise     Daily     Weekly     Monthly     Rarely

History of substance abuse?    No    Yes

Smoke currently?    No    Yes    \_\_\_\_\_ packs per day

Quit smoking?    Yes    \_\_\_\_\_ when

Drink alcohol?     Daily     1-2 /week     1-2/month     1-2/year

Illegal drugs?    No    Yes

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I, the undersigned agree, to be financially responsible for all charges incurred by me or dependents with the physicians of Minimally Invasive Surgeons of Greater Hartford LLC. I understand that MISOGH will submit my charges to my insurance carrier for reimbursement from my insurance carrier. I understand that it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment. Furthermore, the information above is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits, or which I am entitled. I will hold no one in this office responsible for any error or omissions that I may have made in the completion of this form.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time that they are rendered unless you are enrolled in an insurance company in which we participate and you have met all requirements of your agreement with that company. For these patients, applicable copays and deductibles will be collected at the time of service. It is our procedure to collect up front any charges incurred by any self paying individuals. We accept payment in the form of cash or check only. In the event that your account must be turned over to a collection agency, a \$35.00 collection fee may be added to your account. If a check used for payment is returned by your bank, a \$25.00 returned check fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy and the policy stated in the paragraph prior to this one.

**Patient or Guardian**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_