Name: _____**Date of Birth:** _____ **Date:** _____
Marital Status: ☐ S ☐ M ☐ D ☐ W Sex: ☐ M ☐ F
Children: ☐ Y ☐ N **How many**: _____ **Ages:** _____
Occupation: _____ **Employer:** _____ **Military:** ☐ Y ☐ N
Handedness: ☐ Right ☐ Left

Social History:

- Cigarette Smoking or Tobacco Use: ☐ Y ☐ N How many packs/day: ☐ <1 pack/day ☐ 1 or >1pack/day
  - Number of Years of Smoking: _____
  - Vaping: ☐ Y ☐ N
- Alcohol Use: ☐ Y ☐ N How often: ☐ Daily ☐ Weekends ☐ Socially ☐ Rarely
- Recreational Substances: ☐ Marijuana ☐ Cocaine ☐ Other _____
- Exercise Regularly: ☐ Y ☐ N ☐ 3-4 times/week ☐ daily ☐ Weekly
- Special Diet: _____ ☐ Low Fat/Low Cholesterol ☐ High Fiber ☐ Low Salt
- Hobbies: _____
- Education: ☐ High School ☐ College ☐ Graduate School ☐ Degree_____
- Living Arrangements: ☐ Own Home ☐ Rent ☐ Condo ☐ living with: _____
- Occupational Hazardous Exposure: ☐ Y ☐ N ☐ Blood/Body Fluids ☐ Toxins ☐ Other_____
- Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other

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Medication Allergies: ☐ Y ☐ N
Medication Name: _____ **Reaction:** _____

Current Medications:
(prescription & over the counter)

☐
☐
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Have you ever been diagnosed with any medical conditions: ☐ Y ☐ N

☐
☐
☐
☐
☐
☐

Have you ever had any surgeries: ☐ Y ☐ N

☐
☐
☐
☐
☐

Family History:

☐ Heart Disease
☐ Hypertension
☐ Diabetes
☐ High Cholesterol
☐ Thyroid Disorders
☐ Kidney Disease
☐ Cancers: _____
☐ Psychiatric Illness _____
☐ Other: _____

EAST GRANBY FAMILY PRACTICE
PATIENT INFORMATION SHEET

IMPORTANT: Please select and circle your Primary Care Physician

Dr. Ewald ***Dr. Howlett*** ***Dr. Ghumman***

Dr. Freedman ***Dr. Reiher*** ***Dr. Lerner*** ***Dr. Pursnani***

PATIENT INFORMATION

Name _____

Address _____

Town _____

State _____ Zip _____

SSN ___ - ___ - _____

Employer _____

Language English Spanish French Other _____

PHARMACY INFORMATION

Name _____

Town _____

Pharmacy Phone/Fax # ( ) _____

Please Circle:

Sex: Female Male

Marital Status: Single Married Widowed Divorced Separated

Date of Birth ___ / ___ / ___

Patient Home ( ) _____

Patient/Parent Work ( ) _____

Patient/Parent Cell ( ) _____

Please circle preferred number - Home Work Cell

E-Mail _____

Emergency Contact _____

Contact Phone # ( ) _____

(preferably outside household)

If this information is not completed IN FULL, your claim may be denied by your insurance company, and become your responsibility. We destroy the previous sheet, old information is not transferable. PLEASE COMPLETE!

INSURANCE INFORMATION	**PRIMARY**	**SECONDARY**
INSURANCE CO.		
ID #		
GROUP #		
SUBSCRIBER INFORMATION		
Subscriber Name		
Subscriber SSN	___ - ___ - ____	___ - ___ - ____
Subscriber DOB	___ / ___ / ____	___ / ___ / ____

Subscriber is: Self Spouse Parent Significant Other other (specify)

PATIENT RESPONSIBILITIES

To assist our patients to understand their financial responsibilities to the practice and additional charges that may be applied to non-payment, missed appointment, cancelled appointments, etc., please note the following:

- I agree to pay **$50.00** fee for any appointment missed or if I fail to notify the office **24 hours** in advance.
- If I fail to pay my co-payment at time of my appointment, I agree to pay a **$10.00** billing charge.
- In divorce cases, remember that the adult seeking treatment is responsible for the bill regardless of their own personal problems. If the court has awarded custody of minor children to one person and financial responsibility to another, **the person bringing the child is responsible for payment of those services at the time of their visit.** A receipt can be provided should you wish to bill your estranged.
- I agree to pay **$25** fee for any check that is returned by my bank.
- If I fail to pay my bill in a satisfactory manner within 60 days and the account is assigned to a collection agency, I will pay the costs of a one time collection fee of **$25.00**. If required I will also be responsible for attorney's fees.
- I understand that the office can only bill for a diagnosis documented in my record, and that to ask the doctor to change a diagnosis to secure insurance payments constitutes fraud.
- We ask that each of our patients now take the responsibility of knowing what their specific health benefits are. Our office will continue to submit insurance claims as a courtesy to our patients. However, we regret that we can no longer commit to knowing what each insurance company will pay on any given procedure.

AUTHORIZATION AND RELEASE: I hereby authorize payment for any services on my behalf be made directly to the doctor. I understand that I am responsible to the doctor for charges not covered by my insurance company. I hereby authorize my physician to release any information required to support my claim, treatment, health care operations and for other purposes that are permitted or required by law.

_____ _____

Patient's Signature or Legal Guardian (Specify relationship to patient) Date

OVER ------->> **OVER ------->>** **OVER ------->>** **OVER ------->>**

Acknowledgement of Receipt of Notice of Privacy Practices

East Granby Family Practice, L.L.C.

13 Church Road, P.O. Box 518
East Granby, CT 06026
Attention: HIPAA Compliance Team
(860) 653-4526

Name of Patient: _____ **D.O.B.** _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient: _____

_____

Do you have an advanced directive/living will? (please circle) **YES** **NO**
If yes, please provide a copy to the doctor.

EAST GRANBY FAMILY PRACTICE, L.L.C.
13 CHURCH ROAD
P.O. BOX 518
EAST GRANBY, CT 06026
PHONE: (860) 653-4526
FAX: (860) 653-5209

AUTHORIZATION TO RELEASE INFORMATION

The HIPAA (Health Insurance Portability and Accountability Act) Privacy Act does not allow for unauthorized disclosure to a patient's family members, friends, or advisors. If the patient would like their protected health information release to someone other than himself or herself they must complete the bottom half of this form. A patient cannot specify which information they would like released to this third party. By completing this form, all protected information may be released to the third party upon request until this agreement is terminated in writing.

I,_____, give East Granby Family Practice,

Permission to discuss with

_____ _____
(Print name) (Relationship to patient)

_____ _____
(Print name) (Relationship to patient)

_____ _____
(Print name) (Relationship to patient)

_____ _____
(Print name) (Relationship to patient)

Permission to leave message on
_____ Home telephone answering machine # _____

_____ Work voice mail # _____

_____ Mobile phone voice mail # _____

Any information pertaining to my healthcare.

Signature: _____

Print Full Name: _____

Date: _____

Witness: _____
(Sign and print full name) This must be physician or staff member of EGFP.

EAST GRANBY FAMILY PRACTICE, L.L.C.

Edward M Ewald, MD
David R Howlett, MD
Khuram Ghumman, MD
Elizabeth S Freedman, MD
Anne M Reiher, MD

13 CHURCH ROAD
P.O. BOX 518
EAST GRANBY, CT 06026
PHONE: (860) 653-4526
FAX: (860) 653-5209

Daniel Lerner, DO
Neena Pursnani, MD
Maryann Webster, APRN
Jeannie Crabtree, APRN
Katherine Taylor, APRN
Krista Pochron, APRN

AUTHORIZATION TO OBTAIN & USE PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

This document authorizes East Granby Family Practice, L.L.C. to obtain and use your Protected Health Information (PHI).

Name of individual(s) and/or practice(s) from which EGFP can receive your PHI from:

Doctor's Name:_____**Phone#:(**_____**)**_____**-**_____

Doctor's City, State:_____**Fax#:(**_____**)**_____**-**_____

Doctor's Name:_____**Phone#:(**_____**)**_____**-**_____

Doctor's City, State:_____**Fax#:(**_____**)**_____**-**_____

Information authorized to be obtained:

- ⌗ All medical information concerning this patient for all dates of service.
- ⌗ Patient summary with most recent visit notes, physical, lab data, immunizations, problem list/past medical history.
- ⌗ Medical information of this patient compiled between ___/___/___ to ___/___/___
- ⌗ Other (specify):_____

Dates of Treatment, if known:_____

The information will be obtained, used, or disclosed for the **following purpose(s)** only:

- ⌗ Other insurance ⌗ Legal process ⌗ At the request of the individual or individual's representative
- ⌗ Assist in the grievance/appeal process ⌗ Assessment/referral/supervisory referral
- ⌗ Other (specify):_____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by sending written notice to the receiving and disclosing entities named above. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event:_____
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine eligibility for enrollment or benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____ _____

Description of Legal Representative Authority Expiration Date of Authorization

NOTICE OF RIGHTS: Information in you medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission, except in limited circumstances, including disclosure to persons who have had risk exposures, pursuant to an order of the court or the Department of Health, among health care providers for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified, unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.