Patient Information - Please Print

Gary Price, M.D., P.C.

Patient's First Name Middle Initial ______ Last Name ☐ Male ☐ Female

Mailing Address

Home # Work # ________________Cell #_________________ Social Security #

EMAIL: ____

Please check box if you would like to receive email notifications of new products and services ☐

*Email addresses will not be released to any other organizations.

Age Date of Birth ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Parent's Name if Patient is a minor ____________________________________ Spouse's Name

Spouse/Parent's Social Security # _____________________________________ Spouse/Parent's Work Phone # _________________

Whom may we contact in case of an emergency ___________________________ Emergency Phone #: ___________________________

Relationship ________________________

Patient Status:

Patient Occupation ____ ☐ Employed ☐ Part-time

Employer ____ ☐ Unemployed ☐Full-time Student

Employer's Address____

Street City State Zip Code

Name of Current Primary Care Physician ____ Phone _______________________

INSURANCE / BILLING INFORMATION

Primary

Insurance Co. ______________________________ Policy/ID # ________________________ Group # ______________________

Subscriber's Name ____________________________________ Subscriber's Employer __________________________ Phone # _______________________

Subscriber's Social Security # __________________ Subscriber's Date of Birth __________________

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other – Explain ______________________

Subscribers Address ____

(If different from Patient's)

Secondary

Insurance Co. ______________________________ Policy/ID # ________________________ Group # ______________________

Subscriber's Name ____________________________________ Subscriber's Employer __________________________ Phone # _______________________

Subscriber's Social Security # __________________ Subscriber's Date of Birth __________________

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other – Explain ______________________

Subscribers Address ____

(If different from Patient's)

IF WORK RELATED INJURY – PLEASE COMPLETE SEPARATE FORM

I hereby authorize Gary J. Price, M.D., P.C. to furnish information concerning my illness and treatments to insurance carriers and any other payor to process to collect this claim and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature ____ Date:

Patient Name Referring Physician ____

Onset of Medical Problem ____________________________________ How did you hear about Dr. Price?____________________________

Reason for today's visit ____

Medical History

Height ______ Weight _______ Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐No How Often? _____________

List all Physicians who are currently treating you ____

Allergies to medications (Please List) ____

Medications currently taking ____

Family History

Check if any blood relative has or has had any of the following and enter relationship.

	Yes	No	Relationship		Yes	No	Relationship
Cancer	☐	☐		Bleeding Tendency	☐	☐	
High Blood Pressure	☐	☐		Heart Attack	☐	☐	
Tuberculosis	☐	☐		Stomach Ulcers	☐	☐	
Diabetes	☐	☐		Kidney Disease	☐	☐	
Epilepsy	☐	☐		Goiter	☐	☐	
Migraine	☐	☐		Colitis	☐	☐	
Asthma	☐	☐		Nervous Breakdown	☐	☐	
Hay Fever	☐	☐		Gout	☐	☐	
Congenital Heart	☐	☐					

Past History (Personal)

Have you had any of the following illness?

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	☐	☐	Allergies (Non-Drug)	☐	☐	Colitis	☐	☐
Angina Pectoris	☐	☐	Frequent Lung Infections	☐	☐	Diabetes	☐	☐
Heart Attack	☐	☐	Cancer	☐	☐	Arthritis	☐	☐
Other Heart Disease	☐	☐	Frequent Kidney or Bladder Infections	☐	☐	Migraine	☐	☐
High blood Pressure	☐	☐	Nervous Breakdown	☐	☐	Headache	☐	☐
Anemia	☐	☐	Depression	☐	☐	Hepatitis	☐	☐
Kidney Disease	☐	☐	Thyroid Disease	☐	☐	Stroke	☐	☐
Gout	☐	☐	Ulcers	☐	☐	Phlebitis	☐	☐
Hay Fever	☐	☐	Gallbladder Disease	☐	☐	"Keloid" Scars	☐	☐
Asthma	☐	☐	Jaundice	☐	☐	Emphysema	☐	☐
Blood Transfusion	☐	☐	Blood Clotting Problems	☐	☐	Other	☐	☐

Please list any other medical condition that you have been treated for in the past, which was not mentioned above ____________________________
____

Have you or any relatives of yours had a reaction to anesthetics? ☐ No ☐ Yes (Describe) ____

Hospitalization (other than operations) – List reasons and approximate dates____

____

Operations: List and indicate approximate year____

____

Serious Injuries (Other than above): List and give approximate dates ____

Gary J. Price, M.D., P.C.

Dear Patient:

Thank you for choosing our office for your medical care.

In the present climate of healthcare reform, our office is making every effort to keep medical costs down for our patients. In order for us to successfully do this, we ask for the cooperation of our patients; please read the Financial Policy carefully. Our main concern is to provide you with good care in a convenient, informative and helpful manner. If you have any concerns about our payment policies, please do not hesitate to ask our office staff.

Payment for office visits (as well as copayment, if it applies) and any in-office surgical procedures are due at the time of service is rendered unless:

1. The doctor participates in your health plan.
1. Your health plan covers these services.
2. Special arrangements are made in advance.

Payments related to cosmetic surgery must be paid in full **Two weeks prior** to the scheduled surgery.

We accept cash, check, Mastercard, or Visa. Return checks will be subject to a ***return check fee of $25.00***.

Charges are the responsibility of the patient or the responsible party. Please remember your insurance policy is a contract between you and your insurance company.

Not all services are a covered benefit in all insurance contracts. We can assist you with your inquiry to your insurance company as to your eligiblity for benefits. **If we do not participate with your insurance, you will be responsible for the difference your insurance company does not pay.**

If the insurance company does not pay your balance in full within **45 days**, we ask that you contact the carrier to help speed things up. If the insurance company does not pay the full amount within **60 days**, we will expect that you make payment on any balance that is due. Balance more than 90 days overdue will be subject to a **1½ % finance charge**.

Finally, we understand that temporary financial considerations may affect timely payment of your balance. We encourage you to communicate any difficulty so that we can assist you in making arrangements for payment schedule. We hope that these efforts are helpful and informative. We are grateful for the opportunity to serve you and appreciate your trust in us.

______________________________________ Date:

Signature of Patient or Responsible Party

Authorization for Disclosure of Information

I Authorize Gary J. Price, M.D. to disclose complete information concerning his medical findings and treatment to the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those individuals who, in Gary J. Price, M.D. sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

______________________________________ Date:

Signature of Patient or Responsible Party

______________________________________ Date:

Witness

Acknowledgement of Receipt of Notice of Privacy Practices

Gary J. Price, M.D., 5 Durham Road, Suite 1 – 8, Guilford, CT 06437

Kathleen Bednarczyk, Patient Coordinator, Tel #:(203)-453-6635 X-305 of Privacy Officer

Name of Patient:

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: ____ 3/16/2010

Print Name: ____________________________________ Telephone #:

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

____

For Office Use Only:

Signed form received by: ________________________________

Acknowledgement refused:

Efforts to obtain: ____

____

Reasons for refusal: ____

____