PATIENT REGISTRATION FORM

SECTION 1: PATIENT INFORMATION

_____
Last Name First Name Mid. Initial

Social Security #: _____ Date of Birth: _____ Gender: M / F

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Legally Separated

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address (*if different than above*): _____

Phone #1 (Primary): _____ Phone #2 (Alternate): _____

Primary Care Provider (PCP): _____ Referring Provider: _____

SECTION 2: GUARANTOR INFORMATION *(Person who has financial responsibility)*

Guarantor's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Phone: _____ Social Security #:_____

Guarantor's Employer: _____ Work Phone: _____

Employer's Address: _____

SECTION 3: EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Emergency Contact Address: _____

Emergency Contact Phone: _____ Relationship: _____

L&M Medical Group is collecting patient demographic data to assist the practice in understanding its patient population to develop the capability, where needed, to provide culturally appropriate medical care and advice.
Please assist us by completing the following:

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race (*Mark one or more*): ☐Asian ☐African American ☐American Indian or Alaska Native
☐Native of Hawaii/Pacific Islander ☐White ☐Decline to Provide

Preferred Language: ☐English ☐Spanish ☐French ☐Dutch ☐Chinese ☐Greek ☐Hindi ☐Russian
☐Portuguese ☐German ☐Other (Please specify): _____

Email Address: _____

SECTION 4: EMPLOYMENT

Employment Status: Full Time Part Time Not Employed Retired Active Military Full-time Student Part-time Student

Employer: _____ Phone Number: _____

Employer Street Address: _____

City: _____ State: _____ Zip: _____

IS THIS A WORK OR AUTO RELATED INJURY? Yes / No / Undetermined

If yes or undetermined, please ask receptionist for additional paperwork.

SECTION 5: SUBSCRIBER INFORMATION *Please present insurance card(s) to receptionist for copying.*

PRIMARY ***(Self / Significant Other / Parent or Guardian)***	**SECONDARY** ***(Self / Significant Other / Parent or Guardian)***
Insurance Name: _____	Insurance Name: _____
Effective Date: _____	**Effective Date:** _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber's Employer: _____	Subscriber's Employer: _____
Subscriber's Date of Birth: _____	Subscriber's Date of Birth: _____
Subscriber S.S. #: _____	Subscriber S.S. #: _____
I.D. # / Policy #: _____	I.D. # / Policy #: _____
Group/Plan #: _____	Group/Plan #: _____

If Medicare is secondary, circle reason: *Working* *Spouse has insurance* *Veteran* *Disabled*

Other: _____

SECTION 6: AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I have been provided a copy of the L+M Medical Group Financial Policy. I authorize treatment and agree to pay all fees and charges for the person named above. I agree to pay all charges shown by statements, promptly upon their presentation, unless credit arrangements are agreed upon in writing.

I authorize payment of insurance benefits be made directly to L+M Medical Group and any assisting providers, for services rendered. I authorize L+M Medical Group to release any medical information necessary to process claims for payment.

I acknowledge I have received L+M Medical Group Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information, and how I can access this information. I understand I am entitled to receive updates upon request if L+M Medical Group Notice of Privacy Practices is amended or changed in a material way. I also understand if I have questions or complaints, I may contact the Privacy Officer at 860-442-0711 ext.4234.

Patient/Guarantor Signature _____ Date: _____

This authorization will remain in effect unless rescinded in writing by the above signed.

For Office Use Only

Completed by: _____

Date Entered: _____

HIPAA PRIVACY NOTIFICATION / DISCLOSURE TO FAMILY AND FRIENDS

Last Name _____ First Name _____ Middle Initial _____

Primary Phone: _____ Date of Birth: _____

Although the majority of your test results will be sent to you by mail within one to two weeks after testing is performed, we may need to contact you by phone about results, appointments, or referrals. You may request the list of people involved with your care be expanded or restricted. You have the right to amend this information at any time. To facilitate contacting you in a timely manner and to comply with federal HIPAA regulations, please complete the information below.

_____ You may only speak to me personally.

_____ You may call me at work. Work Phone: _____ Ext. _____

_____ You may call my cell phone. Cell Phone: _____

_____ You may leave a message on my answering machine or voicemail regarding those items checked below at:

___ Home ___ Work ___ Cell

_____ You may leave a message regarding those items checked below with the following family members:

___ Spouse / Name: _____ Phone: _____

___ Children / Name: _____ Phone: _____

___ Parent / Name: _____ Phone: _____

___ Other / Name: _____ Phone: _____

___ Other / Name: _____ Phone: _____

	BLOOD WORK		**REFERRALS**		**APPOINTMENTS**
	PAP SMEAR		**MAMMOGRAM**		**CULTURES**
	XRAYS		**EKG**		**CT / MRI**
	PRESCRIPTIONS		**ALL OF THE ABOVE and/or any other test performed**		

Results regarding sexually transmitted diseases, whether positive or negative, will ONLY be given to the Patient.

I understand that L+M Medical Group will make reasonable efforts to accommodate this request for as long as I am a patient; but I can request a change at any time. I further understand that in some emergency situations, my protected health information may be released.

_____ _____

Patient / Parent / Guardian Signature *Date*

Patient Financial Policy

If you have a question about your bill or the status of your account, please call the L+M Medical Group billing office at (860) 464-3040.

Thank you for choosing L+M Medical Group as your healthcare provider. We are committed to delivering outstanding healthcare. We are sure you understand that payment for this healthcare is your responsibility. The following is a statement of our payment policy. This payment policy applies to all services provided by L+M Medical Group regardless of the location.

All patients are expected to complete a patient information and financial responsibility form annually. An updated patient information form must be completed if there have been any changes A valid insurance card, if applicable, is required to be presented for copying at each visit. Failure to provide correct information at the time of your visit may result in responsibility for the cost of the entire visit.

For our Patients with Medical Insurance Benefits:
The providers of L+M Medical Group participate in most major health plans. We have contracts with many HMO's, PPO's, insurance companies and government agencies including Medicare and Medicaid. Our business office will submit a claim for any services rendered to a patient who is a member of one of these plans. It is the patient's responsibility to provide all necessary information and complete any required forms before leaving the office. If you provide us with secondary insurance information at the time of service, we will automatically file a claim after payment from the primary payer. L+M Medical Group does not currently submit tertiary insurance claims.

If a patient is a member of an insurance plan, which L+M Medical Group does not participate with, our office will file a claim on the patient's behalf; however, the patient is expected to make payment in full at the time of service. A 25% prompt pay discount will be offered to the patient at the time of service. Please contact your insurance company with any questions about your insurance coverage.

We **cannot** waive co-payment, deductibles, co-insurance or non-covered service amounts defined as patient responsibility under the terms of our contract with the various health plans. Payment of co-payments and co-insurances are due at the time of the office visit. Please be ready to make payment on the day you visit the office. Any remaining balance on your account after the insurance company has processed your claim is due upon receipt of a statement from our office.

For our Patients with no Medical Insurance Benefits:
If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit. If you pay the charges in full on the day of service, we will offer a 25% prompt pay discount. Partial payments or payments made after the date of service are not subject to the prompt pay discount.

Please let us know if you are having difficulty paying your account. L+M Medical Group may be able to help by setting up a payment plan based on your financial condition, call (860) 464-3040 for assistance. We offer payment plans as well Charity Care.

Liability Accounts
If you have been involved in an automobile accident, you must notify your auto insurance carrier that you were injured. All medical expenses incurred as a result of an automobile accident must utilize the automobile insurance benefits for payment until these benefits have exhausted the dollar amount of your coverage. Once the auto coverage has been exhausted, your health insurance will take over for coverage and payment of your medical expenses (the auto insurance will send a letter which must be forwarded to the health insurance carrier before they will pay claims). You will be responsible for any co-pays, co-insurance or deductibles. We require your automobile insurance identification card, the claim number assigned to your accident and all of your active health insurance identification cards for your first appointment. We do not accept an attorney's letter of protection. You are responsible for providing the

necessary information to bill the responsible party. If payment is unable to be obtained in 60 days, charges for the services rendered will become the patient's responsibility.

For all other liability injuries, your medical insurance will be billed and you will be responsible for any co-pays, co-insurances or deductibles.

Workers Compensation
If you are being seen for an injury or illness as a result of your job, we must have written or verbal authorization from your employer to confirm this and their directions as to how to bill for this service. If we do not have this information we will provide you with the necessary forms to expedite your claim. Upon receipt of a Form 43 denial, you will be responsible for all charges.

Missed Appointments
A patient who is a no-show more than three times may be dismissed from L+M Medical Group.

Methods of Payment
Cash, personal check, Visa, MasterCard or American Express are accepted methods of payment by L+M Medical Group for professional services.

Past Due Accounts
All patient-responsible balances that remain delinquent after 120 days, with no response to requests for payment, may be referred to a collection agency. Once an account is turned over to the collection agency, the patient or responsible party will have to settle the debt with the agency. The patient or responsible party agrees that we may recover all costs and expenses incurred in the collection efforts, including any interest due, court costs and reasonable attorney fees. Please be aware that if a balance remains unpaid, you and/or your immediate family members may be discharged from L+M Medical Group. If this occurs, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30 day period, our providers will only treat you on an emergency basis.

Thank you for complying with our financial policy. If you have any questions regarding your bill or the status of your account, please call the L+M Medical Group billing office at (860)464-3040.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. In the event there are amendments to this policy, requests to sign the updated policy will be provided to all patients.

_____ _____
Signature of Patient or Responsible Party if a Minor Date

_____
Please Print the Name of the Patient

Patient Medical History Form

Today's Date: _____ Date of Birth: _____

Name: _____
Last First Middle

Medical History

Have you ever had any of the following medical problems?

CONDITION	√	DATE	CONDITION	√	DATE	CONDITION	√	DATE
ADHD			Enlarged Prostate			Obesity		
Allergies			Enlarged Thyroid/Goiter			Pain, chronic		
Alzheimer's			Fibromyalgia			Parkinson's Disease		
Anemia			Fainting			Peripheral vascular dz		
Anxiety Disorder			GERD			Positive TB test		
Arthritis			Glaucoma			Prostatitis, chronic		
Asthma			Gout			Psoriasis		
Atrial fibrillation			Hearing loss			Rheumatic fever		
Back pain			Hematuria			Rheumatoid arthritis		
Bipolar d/o			Hemorrhoids			Schizophrenia		
Bleeding d/o			Hepatitis C			Seizures		
Blood clot, leg			High Blood Pressure			Sinusitis, chronic		
Cancer - Breast			High Cholesterol			Sleep d/o		
Cancer – Prostate			HIV Disease			Sciatica		
Cancer –Type:			Hyperthyroidism			Stroke		
Cataract			Hypothyroidism			Substance Abuse		
Congestive Heart Failure			Irregular Heart Beat			TIA		
COPD/Emphysema			Irritable Bowel Syndrome			Tuberculosis		
Coronary Art Disease			Insomnia			Ulcer		
Crohn's Disease			Intestinal Bleed			Ulcerative Colitis		
Depression			Kidney Failure			Underweight		
Diabetes Mellitus I			Kidney Infection			Urinary incontinence		
Diabetes Mellitus II			Kidney Stones			Vein problems		
Diverticulitis Colon			Liver Failure			Venereal disease		
Dizziness/Vertigo			Migraine					
Eating Disorder			Multiple Sclerosis					
Emphysema			Neuropathy					
Other:			Other:			Other:		

Name: _____ Date of Birth: _____
Last First Middle

Surgical History

Have you ever had any of the following medical procedures?

SCREENING PROCEDURE	DATE	LOCATION / RESULT
Colonoscopy		
Mammogram		
Pap Smear		
Bone Density/DEXA		
Prostate Cancer Screen		
Pneumonia vaccine		
Influenza vaccine		
Tetanus shot		
EYE/EAR/NOSE/THROAT	**DATE**	**TYPE / SURGEON / HOSPITAL**
Cataract Surgery		
Laser Eye Surgery		
Tonsillectomy		
Tympanostomy Tube		
HEART	**DATE**	**TYPE / SURGEON / HOSPITAL**
Angioplasty		
Coronary Bypass		
Pacemaker/Defibrillator		
BREAST/LUNG:	**DATE**	**TYPE / SURGEON / HOSPITAL**
Breast Surgery		
Lung Surgery		
Pacemaker/Defibrillator		
GASTROINTESTINAL	**DATE**	**TYPE / SURGEON / HOSPITAL**
Appendectomy		
Cholecystectomy (Gall bladder)		
Other		
REPRODUCTIVE	**DATE**	**TYPE / SURGEON / HOSPITAL**
Colposcopy		
Conization of cervix/LEEP		
Cesarean Section		
Hysterectomy		
Vasectomy		
Other		
JOINT/SPINAL/BRAIN	**DATE**	**TYPE / SURGEON / HOSPITAL**
Joint Surgery		
Spinal Surgery		
Brain Surgery		
SKIN	**DATE**	**TYPE / SURGEON / HOSPITAL**
Skin Surgery		
ENDOCRINE	**DATE**	**TYPE / SURGEON / HOSPITAL**
Thyroid Surgery		
Other		
OTHER	**DATE**	**TYPE / SURGEON / HOSPITAL**
Other (Type):		
Other (Type):		

Name: _____ Date of Birth: _____
Last First Middle

Are you experiencing any of the following symptoms?

NO	YES	CONSTITUTIONAL	NO	YES	BREAST	NO	YES	MUSCULOSKELETAL
		Fatigue			Discharge from nipple			Neck stiffness
		Weight loss			Breast tenderness			Neck pain
		Weight gain			Breast mass			Back stiffness
		Fever	NO	YES	GASTROINTESTINAL			Back pain
		Chills			Loss of appetite			Joint swelling
NO	YES	EYES			Trouble eating			Joint pain
		Double vision			Abdominal Pain			Limitation of joint movement
		Blurred vision			Nausea			Muscle pain
		Sensitivity to light			Vomiting	NO	YES	SKIN
		Reduced vision			Change in bowel habits			
		Eye redness			Diarrhea			Skin rash/lesion
		Eye itching			Constipation			Dry/itchy skin
		Eye pain			Blood in stool			Nail problem
NO	YES	EARS	NO	YES	GENITAL/URINARY	NO	YES	NEUROLOGIC
		Ear discharge			Pain when urinating			Headache
		Ear pain			Blood in urine			Dizziness
		Tinnitus			Discharge			Lightheadedness
		Hearing loss			Dribbling of urine			Fainting
NO	YES	NOSE/THROAT			Frequent urinating at night			Dizziness/Vertigo
		Nasal congestion			Testicular mass			Weakness
		Nasal discharge			Testicular pain			Numbness/Tingling
		Postnasal drip			Problems with erections			Tremor
		Sneezing	NO	YES	HEMATOLOGIC, LYMPHATIC	NO	YES	PSYCHIATRIC
		Epistaxis			Swollen glands			Difficulty Sleeping
		Sore throat			Lymph node tenderness			Mood swings
		Bleeding gums			Anemia			Feeling anxious
		Hoarseness			Bruise easily			Feeling depressed
NO	YES	RESPIRATORY			Bleed easily			Confusion
		Shortness of breath						Memory loss
		Cough				NO	YES	ENDOCRINE
		Coughing up blood						Hungry frequently
		Wheezing						Drinking a lot
		Pain with breathing						Urinating a lot
NO	YES	CARDIOVASCULAR						Enlarged thyroid
		Chest pain						Intolerant of cold
		Palpitations						Intolerant of heat
		Irregular heart beat				NO	YES	ALLERGIC, IMMUNOLOGIC
		Shortness of breath lying down						Hives
		Swelling						Susceptibility to infections
		Pain in legs when walking						Wound healing impairment

Name: _____ Date of Birth: _____
Last First Middle

FAMILY HISTORY				
CARDIOVASCULAR	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Heart Attack / Heart disease				
High Cholesterol				
High Blood Pressure				
Sudden Death				
ENDOCRINE	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Diabetes Mellitus				
Thyroid Disorder				
Other endocrine problem:				
EYES/EARS/NOSE/THROAT	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Glaucoma				
Hearing Problems				
Visual Problems				
GENITAL/URINOLOGY	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Endometriosis/ Ovary/Uterine Disease				
Kidney/Bladder Disease				
Problems with Pregnancy				
HEMATOLOGIC	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Bleeding/blood Disorder				
Sickle Cell Anemia				
MENTAL HEALTH/SUBSTANCE ABUSE	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Attention Deficit Disorder				
Alcoholism or Substance Abuse				
Bipolar Disorder				
Depression				
Schizophrenia				
MUSCULOSKELETAL	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Osteoarthritis				
Osteoporosis				
Rheumatoid Arthritis / Lupus				
NEUROLOGIC	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Alzheimer's Disease / Dementia				
Migraine				
Stroke				
CANCER	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Breast Cancer				
Colorectal/stomach/intestine Cancer				
Endometrial/Ovarian Cancer				
Lung Cancer				
Prostate Cancer				
Skin Cancer/Melanoma				
Cancer-Other				
RESPIRATORY	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Asthma				
Pulmonary Embolism				
Respiratory Disorder				
Tuberculosis				
OTHER	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Other problems of any type				
Genetic/Birth Defects				

Name: _____ Date of Birth: _____
Last First Middle

SOCIAL HISTORY

	YES	NO		
Do you use tobacco?			If yes, what form and how much?	
			If no, did you ever?	
			When did you quit?	
Exposure to second hand smoke?				
Do you drink alcohol?			If yes, how many drinks in 1 week?	
Do you drink caffeine?			If yes, what type and how much?	
Have you had a lot of sun damage?				
Do you use sunscreen?				

How would you rate your diet		Great		Average		Poor
Are you on a special diet?		Yes		No		
Do you use illicit drugs?		Yes		No		
Do you exercise?		Yes		No	If yes, how many times a week?	
Are you sexually active?		Yes		No		
Are you sexually active with:		Males		Females		Both
Do you use your cell phone while driving? (texting, talking, etc)		Yes		No		
Is there anything else you would like your doctor to know about you?		Yes		No		
If yes, please explain:						
Do you have cultural preferences or needs you would like the office to be aware of:						
How would you rate your dental health?		Great		Average		Poor

OTHER PROVIDERS OF CARE

Provider's Name	Reason for Seeing / Specialty	Date of Last Visit

Name: _____ Date of Birth: _____
Last First Middle

CURRENT MEDICATIONS AND SUPPLEMENTS
(Prescription or Over-The-Counter)

Name of Medication	Dose/Frequency	Prescribing Physician (if not PCP)	Reason for Taking

ALLERGIES

Allergen	Describe Reaction	Medication Taken	Date of last occurrence

ADDITIONAL NOTES