Name: _____ Phone (Cell): _____

Address: _____ Phone (W) (H): _____

_____ Age: _____ Date of Birth: _____
City State Zip

Emergency Contact: _____ Relationship: _____ Phone: _____

Email Address: _____ Pharmacy Name & Phone: _____

Have you been our patient before? _____ Social Security #: _____

Authorization to leave a message: □ YES □ NO
If using insurance today (Please provide your insurance card and your ID)
Company Name: _____ **Member ID:** _____

EXISTING PATIENTS NEED ONLY TO FILL OUT CHANGES IN THE FOLLOWING:

Pregnancy History

Prior Pregnancies (not including now) _____ Number of living children _____
Full Term _____ Premature _____ Vaginal Births _____ Cesarean _____ Miscarriages _____ Abortions _____
Ectopic Pregnancies _____ Molar Pregnancies _____ Other Complications: _____
Date of Last Menstrual Period: _____ Your Blood Type (if known): _____ □ Positive □ Negative

Gynecological History
(Please mark any you have now or have had in the past)

□ History of STD's: □ Gonorrhea □ Chlamydia □ Trichomonas □ Syphilis □ Herpes □ HIV □ HPV
□ History of Abnormal Paps □ Colposcopy □ Cryosurgery □ Leep/Cone Biopsy □ Fibroids Abnormality
What is the reason for today's visit?: □ Annual □ Problem, explain _____

General Health Questions

Are you in good health? □ YES □ NO, explain _____
Conditions presently being treated: _____, _____, _____
List previous surgeries (and year): _____, _____, _____
Other hospitalizations: _____
Have you ever had any abnormal bleeding associated with previous surgery or trauma: □ YES □ NO
Previous blood transfusions: _____
ALLERGIES to any drug or substance: □ YES □ NO
List any and all substances to which you are allergic: _____
Have you or any family member had a history of medical conditions?: □ YES □ NO
Who?: _____ What was the condition?: _____
Are you taking any medications at this time?: □ YES □ NO (**Please List**) _____
Do you smoke?: □ YES □ NO Substance Abuse?: □ YES □ NO (Type) _____

Medical History
(Please indicate YES or NO for any conditions even if you no longer have them)

	YES	NO		YES	NO		YES	NO
Heart Disease.....	□	□	Hepatitis.....	□	□	Tumors/Growths.....	□	□
Heart Murmur.....	□	□	Diabetes.....	□	□	Infections.....	□	□
Mitral Valve Prolapse.....	□	□	Asthma.....	□	□	Swollen Lymph Glands....	□	□
Congenital Heart Defects	□	□	Shortness of Breath.....	□	□	Emotional Problems.....	□	□
Rheumatic Fever.....	□	□	Lung Disease.....	□	□	Anxiety.....	□	□
Heart Attack.....	□	□	Tuberculosis.....	□	□	Psychiatric Care.....	□	□
Pacemaker.....	□	□	Emphysema.....	□	□	Frequent Headaches.....	□	□
Stroke.....	□	□	Liver Disease.....	□	□	Sinus Trouble.....	□	□
High Blood Pressure.....	□	□	Seizures.....	□	□	Hives/Rash.....	□	□
Low Blood Pressure.....	□	□	Ulcers.....	□	□	Thyroid Disorder.....	□	□
Scarlet Fever.....	□	□	Kidney Disease.....	□	□	Epilepsy.....	□	□
Chest Pain.....	□	□	Anemia.....	□	□	Cancer Treatment.....	□	□

I have read (or have had read to me) the foregoing evaluation and I certify that the information I have provided above is correct to the best of my knowledge.

SIGNED BY PATIENT: _____ DATE: _____

General Consent for treatment and Acknowledgement Form

_____ I being of legal age, give consent to authorities of BSSI to administer any treatment, medical or surgical including anesthesia, that the officials or **BSSI** may deem necessary for the restoration of health to the patient names below during this visit.

_____I consent to use my protected health information by BSSI to any person or organization for the purpose of carrying out treatment, obtaining payment or conducting healthcare operations. Protected health information used or disclosed by BSSI may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information as long as such information is disclosed in accordance with Connecticut and Federal Law, which require you to provide specific authorization. I understand that information regarding how BSSI of Privacy Practices. I understand that this consent is effective for as long as BSSI maintains my protected health information.

BY SIGNING BELOW, I UNDERSTAND AND ACKNOWLEGEDGE THE FOLLOWING:

_____ I have read and understand this consent. I have received BSSI Notice of Privacy Practices currently in effect.
If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual:
_____

Unable to obtain written consent and acknowledgement because:
☐ Individual refused ☐ Emergency treatment situation ☐ Individual not able to sign due to incompetence or other medical reason

A Message to our Patients

Our physicians and nurse practitioners are the providers of medical care. All medical or health care questions and issues need to be addressed with the doctor or nurse practitioner who is providing care, and rendering treatment to you. It is your responsibility to ask the treating physician or nurse practitioner if there are any issues concerning your care and treatment that you do not understand.

For More Information or to Report a Complaint

If you have a question or want to report a complaint, please contact our Privacy Officer, at (954)726-7770. Complaints may also be filed with the Secretary of Health and Human Services. We will not retaliate against you for filing.
I have read this privacy notice and I have been given ample time to ask questions regarding the information it contains. I understand Dr. Benjamin will hold my records to the highest standard of privacy and confidentiality and will only release my personal health information when authorized by me in writing, or when required by law to do so.

ASSIGNMENT OF BENEFITS

____ I HEREBY AUTHORIZE _____ COMPANY TO PAY DIRECT TO BSSI, all benefits due me, if any, by reason of service described for in the policy contract with aforementioned insure company. I will pay BSSI for all such charges incurred of for all charges in excess of whatever sums may be paid by the insurance company above mentioned, but not to exceed the balance of the facilities regular charges for this visit.

AUTHORIZATION TO RELEASE INFORMATION

____ I authorize BSSI to release to my insure(s) or their agent(s) any and all medical information as may be necessary for payment of my visit medical claim I understand that refusal to grant such consent will not jeopardize my right to continue to obtain treatment, except where disclosure are necessary for treatment .If the information released to treatment relates to alcohol/drug abuse, the information is subject to the requirements of Federal regulation Part 2 of Title 42 which prohibits future release unless my consent is granted or it not required by regulations. This release also allows information to be released of third party utilization review/final audits, workers compensation and automobile insurance claim. Authorize BSSI to release the information necessary to assist in my need for continuing care, to my primary care physician and other healthcare providers. I understand that this authorization may be revoked at any time except to the extent that action has ready been taken in reliance upon it. This authorization will expire 180 days after appearing below.

MEDICARE: Medicare Certification and Authorization

____ I certify that the information given by me in applying under Title XVIII of the Social Security Act is correct. I request payment of authorized Medical benefits to me, or no my behalf, any services furnished to me by BSSI including physician services. I authorize any holder of medical and other information about me to be released to Medicare and its agents any information needed to determine the benefits of related services.

BY MY SIGNATURE BELOW I VERTIFY THE FOLLOWING:

1. I understand that I am responsible for the notification to my insurance company to obtain authorization before services are rendered I understand that if this is not done, insurance benefits may be reduced.
2. If I am an outpatient, I consent Outpatient treatment and or testing as ordered by a physician.
3. I understand that I am responsible for all charges not covered by my insurance company.
4. I understand the above Conditions of Care, I agree to the terms specified, I am authorized to execute this form if admitted receive a copy of this form.
5. I understand that my name may be placed on a Patient Status Board to facilitate my care while at BSSI

Your signature indicates full acceptance acknowledgement of each applicable paragraph marked by your initials, or an (x)

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Staff Witness Name	Staff Witness Signature	Date