FRANCINE D YORK, DNP, APRN, FNP-BC

PATIENT REGISTRTION FORM

PERSONAL INFORMATION:

Name: ____ Date of Birth: ______/______/______ Sex: ☐ Female ☐ Male

Address: _____________________________Town: ______________________ State: _______ Zip Code: ___________

Phone Number: (______) ________________ Is it ok to leave a detailed voicemail at this number?: ☐ Yes ☐ No

Cell: (______) ________________ Is it ok to leave a detailed voicemail at this number?: ☐ Yes ☐ No

Work: (______) ________________ Is it ok to leave a detailed voicemail at this number?: ☐ Yes ☐ No

Email: _______________________________________ Can we email you a link to our patient portal? ☐ Yes ☐ No

Social Security #: ______________________________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Disabled ☐ Child ☐ Student

If Employed: Employers Name/Address: ____

If you are a Student, are you attending: ☐ High School ☐ College Highest grade completed: ____________

Primary Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Portuguese ☐ Other: ____________________

Race: ☐ White ☐ Black/African-American ☐ Asian ☐ American Indian/ Alaskan Native

☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____________________________ ☐ Declined to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify

Are you a Veteran or a spouse of a Veteran?: ☐ Yes, Veteran ☐ Yes, Spouse ☐ No

Preferred Pharmacy: ______________________________________ Phone Number: (______) __________________

Emergency Contact: ______________________________________ Phone Number: (______) __________________

Relationship: _________________________________ May we speak to this contact regarding your care: ☐ Yes ☐ No

Emergency Contact: ______________________________________ Phone Number: (______) __________________

Relationship: _________________________________ May we speak to this contact regarding your care: ☐ Yes ☐ No

INSURANCE INFORMATION:

Primary Medical Insurance: __________________________________ Policy Number: __________________________

Secondary Medical Insurance: _______________________________ Policy Number: __________________________

☐ Copy of card given Insured Party: ☐ Self ☐ Spouse ☐ Parent

Party responsible for payment: ☐ Spouse ☐ Parent ☐ Other: _____________________________________

Please complete this section ONLY if someone other than the client is responsible for payment:

Name: ____ Date of Birth: ______/______/______ Sex: ☐ Female ☐ Male

Address: ___________________________________ Town: ________________ State: _______ Zip Code: ___________

Phone Number: (______) ________________ Cell: (______) _________________ Work: (______) _________________

Revised: January 1, 2020

55 HAZARD AVENUE ENFIELD, CT 06082
PHONE: 860.744.2244 FAX: 860.744.2220 | WWW.BEARPONDHEALTH.COM

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Last Name: ______________________ **First Name:** ________________________ **Date of Birth.:** ______/______/______

SOCIAL HISTORY:

Do you use tobacco products now or did you smoke in the past? ☐ Yes ☐ No If yes, what type: _________________

How many a day? __________________ How many years? __________________ Age stopped? __________________

If you currently use tobacco products, are you ready to quit? ____

About how much alcohol do you consume on an average day? __________________ or week ______________________

Do you sometimes use street drugs (cocaine, marijuana, heroin, etc.)? ____

MEDICATION HISTORY:

List all medications- include hormones, birth control pills, eye drops, vitamins, inhalers, creams, nasal sprays, and over the counter medicines. ☐ Check here if none

Medication/Dose	Reason	Medication/Dose	Reason

List any allergies with reaction you have to medicines, foods, insects, etc.:

____

____

RISK SCREENING:

Do you always wear seatbelts in a car? ☐ Yes ☐ No

Do you wear helmets when appropriate? ☐ Yes ☐ No

Do you wear sunscreen when appropriate? ☐ Yes ☐ No

Do you have working smoke and carbon monoxide detectors? ☐ Yes ☐ No

Do you have any unsecured firearms in your home? ☐ Yes ☐ No

CURRENT HEALTH ISSUES:

What health problems would you like to discuss with your provider at today's visit?

____

____

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BEAR POND
FAMILY MEDICINE
PEDIATRICS

FRANCINE D YORK, DNP, APRN, FNP-BC

Last Name: ____________________ **First Name:** ______________________ **Date of Birth.:** ______/______/______

FAMILY ILLNESSES:

Please list which relative has/ has had the medical condition.

(M)- Mother (F)- Father (S)- Sister (B)- Brother (C)- Children

☐ I don't know my family history ☐ I am adopted

MEDICAL CONDITION	FAMILY MEMBER	MEDICAL CONDITION	FAMILY MEMBER	MEDICAL CONDITION	FAMILY MEMBER
☐ Aneurysm		☐ Depression		☐ Mental Illness	
☐ Anxiety Disorder		☐ Diabetes		☐ Osteoporosis	
☐ Arthritis		☐ Genetic Screening		☐ Ovarian Cancer	
☐ Asthma		☐ Glaucoma		☐ Parkinsonism	
☐ Autoimmune Disease		☐ Heart Attack		☐ Prostate Cancer	
☐ Birth Defects		☐ Heart Disease		☐ Stroke	
☐ Breast Cancer		☐ Hyperlipidemia		☐ Substance Abuse	
☐ Celiac Disease		☐ High Blood Pressure		☐ Sudden Death	
☐ Colon Cancer		☐ Kidney Disease		☐ Thyroid Disease	
☐ COPD		☐ Learning Disabilities		☐ Transient Ischemic Att.	
☐ Chron's Disease		☐ Lung Cancer		☐ Ulcerative Colitis	
☐ Dementia		☐ Melanoma			

MEN:

Are you sexually active? ☐ Yes ☐ No

How many partners in the past 5 years? __________

Men, women, or both? __________

Do you use contraception? ☐ Yes ☐ No

If yes, what type? ____________________________

Do you have problems with intercourse? ☐ Yes ☐ No

When was your last prostate screening? __________

Do you examine your testicles for lumps? ☐ Yes ☐ No

Date of last colonoscopy: ______/______/______

WOMEN:

When was your last menstrual period? __________

Do you have problems with periods? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

How many partners in the past 5 years? __________

Men, women, or both? __________

Do you use birth control/contraception? ☐ Yes ☐ No

If yes, what type? ____________________________

Number of pregnancies: __________

Number of births: __________

Date of last pap smear: ______/______/______

Date of last mammogram: ______/______/______

Do you check your breasts for lumps? ☐ Yes ☐ No

Date of last bone density test:
______/______/______

Date of last colonoscopy: ______/______/______

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Last Name: ______________________ **First Name:** ______________________ **Date of Birth.:** ______/______/______

MEDICAL CONDITIONS:

Please check any of the following medical conditions you have/had.

☐ Attention deficit/hyperactivity	☐ Diverticulitis	☐ Brain/Spinal Cord Infection
☐ Allergic Rhinitis	☐ Dysrhythmia	☐ Heart Attack
☐ Anemia	☐ Eating Disorder	☐ Obesity
☐ Anxiety	☐ Emphysema	☐ Osteoporosis/Brittle Bones
☐ Arthritis	☐ Failure to thrive	☐ Pneumonia
☐ Asthma	☐ Gait Disturbance	☐ Psoriasis
☐ Atrial Fibrillation	☐ GERD/Acid Reflux	☐ Peripheral Artery Disease
☐ Back Pain	☐ Gastrointestinal Bleeding	☐ Seizures
☐ Bipolar Disorder	☐ Glaucoma	☐ Skin Cancer
☐ Benign Prostatic Hyperactivity	☐ Gout	☐ Spine Disorder
☐ Coronary Artery Disease	☐ Headaches	☐ Stroke
☐ Cancer	☐ Hearing Loss	☐ Substance Abuse
☐ Cardiac Disease	☐ Hematuria	☐ Thromboembolism/Blood Clot
☐ Cataracts	☐ HIV/AIDS	☐ Thyroid Disease
☐ Congestive Heart Failure	☐ Hyperlipidemia	☐ Tremor
☐ Cerebrovascular Disease	☐ High Blood Pressure	☐ Tuberculosis
☐ Bleeding Problem	☐ Hypogonadism	☐ Ulcers (Gastrointestinal)
☐ Chronic Bronchitis/COPD	☐ Inflammatory Bowel Disease	☐ Bladder Infection
☐ Dementia	☐ Kidney Disease	☐ Chicken Pox
☐ Depression	☐ Kidney Stones	☐ Vision Problems
☐ Diabetes	☐ Liver Disorder	☐ **NONE**

Any additional medical history: ____

SURGICAL HISTORY:

☐ Adenoidectomy	☐ Plastic Surgery	☐ Pacemaker
☐ Appendectomy	☐ Cystoscopy	☐ Parathyroid Surgery
☐ Bladder Surgery	☐ Eye Surgery	☐ Sinus Surgery
☐ Brain Surgery	☐ Fracture Surgery	☐ Skin Surgery
☐ Breast Surgery	☐ Heart Surgery	☐ Spine Surgery
☐ Heart Bypass	☐ Hernia Repair	☐ Splenectomy
☐ Cardiac Valve Surgery	☐ Hysterectomy	☐ Thyroid Surgery
☐ C-Section	☐ Joint Replacement	☐ Tonsillectomy
☐ Carpal Tunnel Release	☐ Lithotripsy	☐ Tubes tied
☐ Gallbladder Removal	☐ Lung Surgery	☐ Vascular Surgery
☐ Colon/Large Intestine Surgery	☐ Oophorectomy	☐ Weight Loss Surgery

Any additional surgical history: ____

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ACKNOWLEDGMENT OF POLICIES

CONSENT TO TREATMENT/ASSISNMENT OF BENEFITS:

I hereby authorize Bear Pond Family Medicine & Pediatrics and associated providers, through its appropriate personnel, to perform or have performed upon me, or the client, appropriate assessment and treatment procedures.

I consent to receive calls and/or text messages from Bear Pond Family Medicine & Pediatrics for my protected healthcare and other services at the phone number(s) provided on the Patient Registration Form. I understand that I may be charged for such calls and/or text messages by my wireless carrier and that such calls and/or text messages may be generated by an automated dialing system.

I hereby assume financial responsibility for and agree to make payment in full to Bear Pond Family Medicine & Pediatrics and associated providers for any and all charges for services received by me and/or any dependents not otherwise authorized or paid by my insurance carrier. Co-payments and fees for services not covered by insurance are required at the time services are rendered. I understand and agree to inform Bear Pond Family Medicine & Pediatrics of changes in my insurance at the time of service so that claims can be filed within the insurance carrier's deadline and I will be responsible for the full fee for services rendered but not covered by my insurance carrier.

I authorize Bear Pond Family Medicine & Pediatrics and associated providers to release my information for all claims and payment purposes, as may be required by my insurance company or any third-party payer, and release Bear Pond Family Medicine & Pediatrics and associated providers from any liability related to such release of information.

I authorize Bear Pond Family Medicine & Pediatrics to disclose any information needed to confirm the validity of my prescription, as well as any information needed to the dispensing pharmacy to whom I present my prescription or to whom my prescription is called/sent/faxed, and to third party payors. ***This information has been disclosed to you from records protected by Federal confidentiality rules (Title 42, Part 2, Code of Federal Regulations [42 C.F.R. Part 2]). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.**

I assign all benefits and rights to payment for services provided by Bear Pond Family Medicine & Pediatrics and associated providers, and authorize payment to be made directly to Bear Pond Family Medicine & Pediatrics and associated providers by any third-party payer that provides benefits or payment for such services.

The HIPAA Privacy Rule requires that "covered entities" (e.g. hospitals and clinics) deliver a copy of their Notice of Privacy Practices to their clients at their first visit. It also requires that we seek a written acknowledgement from our clients that we did, in fact, deliver that notice.

***NOTICE TO PATIENTS:* When a new baby enters the world at Johnson Memorial, your provider may need to leave the office to care for the little one. This can happen with very little notice to reschedule the day's appointments. We will do everything in our power to accommodate your needs. Thank you for your patience and understanding**

Accordingly, Bear Pond Family Medicine & Pediatrics asks you to acknowledge that we delivered to you a copy of our "Notice of Privacy Practices" and "Office Policies" by signing this form.

Signature of Client/Parent/Legal Representative Date Print Name

If not signed by the client indicate relationship of authorizing person to client:

☐ Parent or guardian of minor child
☐ Guardian or conservator of conserved client
☐ Beneficiary or personal Representative of a deceased individual

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CONTROLLED MEDICATION AGREEMENT

Controlled Medications are governed by multiple Federal and State laws and monitored through multiple agencies. Monitoring agencies include the Drug Enforcement Agency (DEA), Connecticut Department of Public Health, Connecticut Board of Medicine, and the Connecticut Board of Pharmacy. Connecticut Board of Nursing Prescribers and pharmacists themselves can monitor any controlled prescription ever filled by a given client (irrespective pf payment type, including cash), by logging on to the Connecticut Prescription Monitoring Program System (aka CTPMP). **If our staff has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies.**

If you need a refill of your prescribed medications prior to your next scheduled appointment, notify your pharmacy to fax this office with your prescription information **(Please do not call the office directly)**. Bear Pond Family Medicine & Pediatrics personnel and/or your provider will be available to fill refills on weekdays during normal office hours only. Please notify your pharmacy at least 48 business hours before your medication runs out or we may not be able to respond to your request.

TERMS AND CONDITIONS: (Please read and the following important information and initial next to each item in the space provided.)

______ I agree to obtain all controlled medications from the same pharmacy. Should the need arise to change pharmacies, I will inform this providers office.

_____ I understand that running out early, needing early refills, increasing doses without permission, and losing prescriptions may be signs of misuse of the medication and may be grounds for immediate discharge from the practice. Bear Pond Family Medicine & Pediatrics will **not** refill a controlled medication if it is lost or misplaced. If a controlled medication is stolen, I will file a report to my local police department.

_____ I understand that Bear Pond Family Medicine & Pediatrics does not do long term pain medication prescriptions and will refer me to pain management.

_____ I agree to follow the dosing schedule prescribed to me by my prescriber.

_____ I agree to never sell or exchange my medications with anyone for any reason. This is a felony and very dangerous.

_____ I understand that medication refills for controlled medication require a scheduled appointment with my prescriber in the office. For this type of medication, refills cannot be called into a pharmacy and dosages will not be adjusted by phone.

_____ I agree to keep all scheduled appointments. **I understand that no medications will be given for canceled or no-show appointments.** I understand that if I am more than 15 minutes late to my scheduled appointment time, I will have to reschedule for another time.

_____ I understand that I will need to be seen monthly, or at the discretion of the provider, for any controlled medications.

_____ **I understand Bear Pond Family Medicine & Pediatrics reserves the right to perform a drug screen every other month, or at the discretion of the provider, and will be performed in the office. Testing positive for illegal drugs, such as cocaine or other illegal substances, will be grounds for immediate termination from the practice.**

_____ I agree to conduct myself in a courteous manner in the office. I agree not to arrive at the office intoxicated or under the influence of drugs. I understand that any misconduct will lead to the termination of my treatment.

_____ I understand that failure to adhere to these policies and/or failure to comply with my providers' treatment plan may result in possible discharge from this practice. **I understand that if I am discharged, it means I can no longer schedule appointments, or receive medication refills.**

_____ **I understand that this agreement does not expire.**

I, the undersigned client, attest that I have read, fully understand, and agree to all of the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this agreement.

____

Signature of Client/Parent/Legal Representative   Date   Print Name

____

Signature of Healthcare Provider   Date   Print Name

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HIPAA AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

Name (First, MI, Last): ____ Date of Birth _______/_______/_______

I, or my authorized representative, authorize disclosure of my Protected Health Information as follows:

BEAR POND FAMILY MEDICINE & PEDIATRICS TO OBTAIN MY MEDICAL RECORDS FROM:
Name of Provider / Office: ____
Address: ____
Phone Number: (_________) _______________________ Fax Number: (_________) _________________________

DATES OF TREATMENT COVERED BY THIS RELEASE:

Date(s) of Treatment: ____

☐ **ALL PRIOR DATES OF SERVICE / TREATMENT, THROUGH DISCHARGE FROM PRESENT DATE OF SERVICE / TREATMENT.**

INFORMATION TO BE RELEASED:

☐ All Records
(**Includes** Mental Health, Alcohol / Drug / Substance, Genetic, HIV / Aids, & Medication History)

Initial ______ Alcohol or Drug Use **Initial** _______ HIV Status or Treatment **Initial** ______ Mental Health Information

☐ Progress Notes ☐ History / Physical ☐ Medication Reports ☐ Radiology Reports ☐ Consult Reports

☐ Lab Reports ☐ Discharge Summaries

This information is to be used for the following purpose(s):

☐ Continuing treatment, care and continuity of care ☐ Disability ☐ Transfer of care ☐ Patient Request

☐ Care coordination or case management ☐ Billing, collection or payment of claims ☐ Other: ___________________________

EXPIRATION:

☐ I **do not** want this authorization to expire ☐ This authorization will expire on: _______/_______/_______

PLEASE SEND REQUESTED INFORMATION TO:
BEAR POND FAMILY MEDICINE & PEDIATRICS
55 Hazard Avenue, Enfield, CT 06082
FAX: 860.774.2220

I have had an opportunity to review and understand the content of this authorization form. By signing this form, I am authorizing Bear Pond Family Medicine & Pediatrics and associated providers to send and/or receive protected health information and that it accurately reflects my wishes.

____

Signature of Client/Parent/Legal Representative Date Print Name

If not signed by the patient, indicate relationship of authorizing person to patient:

☐ Parent or guardian of minor child

☐ Guardian or conservator of conserved patient

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Redisclosure notice to client: If the person(s) and/or organization(s) listed on the front side are not health care providers, health care clearinghouses, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization(s) redisclose your health information.

Disclosure notice to recipient of client health care records: You are prohibited from making any further disclosure of client health care records without the specific written authorization of the person who is the subject of such records.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your rights with respect to this authorization:

- *Right to receive copy of this authorization* — You have the right to receive a copy of this authorization.
- *Right to refuse to sign this authorization* — You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization.
- *Right to withdraw this authorization* — You understand that if you want to cancel this authorization, you must do so in writing. To obtain a form to cancel this authorization, you may contact our office staff. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) listed above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- *Right to inspect a copy of the health information to be used or disclosed* — You understand that you have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form. You may arrange to inspect your health information or obtain copies of your health information by contacting our office staff.
- *HIV test results* — Your HIV test results may be released without your authorization to persons/organizations that have access under Connecticut law and a list of those persons/organizations is available upon request.