SUFFIELD
PRIMARY CARE PHYSICIANS

New Patient Form

230 B Mountain Rd.
Suffield, CT 06078
Phone: (860) 668-4767
Fax: (860) 668-6600

Name:_____

D.O.B._____ Social Security Number:_____

Address:_____
_____

Phone Number:_____ Alternate Number:_____

Primary Health Insurance:_____

Secondary Health Insurance:_____

Policy Holder:_____

D.O.B._____ Social Security Number:_____

Address:_____
_____

Who is your employer?_____

Why are you seeing the doctor today?_____

Is your injury/pain on the right or left side?_____

When did your symptoms begin?_____

Is your injury work related? Yes/No

Is your injury related to a motor vehicle accident? Yes/No

Who is your primary care physician?_____

Address_____

Phone Number:_____

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Patient Medical and Social History

Name:_____ D.O.B._____ Ht:_____ Wt:_____

Please list all medications that you are currently taking:_____
_____
_____

Do you have any allergies? Yes/No
If yes, please list:_____

In your medical history, have you had problems with the following?

Arthritis	Yes/No	AIDS/HIV	Yes/No
Bleeding Disorders	Yes/No	Breathing or Lungs	Yes/No
Blood Pressure	Yes/No	Bowel or Bladder	Yes/No
Ears/Nose/ Throat	Yes/No	Eyes	Yes/No
Fainting	Yes/No	Gout	Yes/No
Hepatitis B or C	Yes/No	Kidneys	Yes/No
Liver	Yes/No	Psychological	Yes/No
Sleep Disorders	Yes/No		

Numbness or Tingling Yes/No If yes, where?_____
Seizure Disorders Yes/No If yes, when was your last seizure?_____
Cancer Yes/No If yes, what type?_____
Diabetes Yes/No If yes, Insulin dependent or Adult Onset?_____

Are you single, married, divorced, separated or widowed?_____
Do you have children? Yes/No If yes, how many?_____
Do you exercise regularly? Yes/No If yes what type?_____
Are you on a special diet? Yes/No
Do you drink alcohol? Yes/No If yes, how often?_____
Do you, or have you ever smoked? Yes/No
Do you have a history of substance abuse? Yes/No If yes, what type?_____

Reviewed by:_____ Date:_____

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INSURANCE INFORMATION AND POLICIES

Dear Patient:
Welcome to CT Family Medicine! Kindly take a moment and read over the following insurance policy, sign and date the bottom of this page. Please remember that this is your insurance policy and it is your responsibility to know and understand your benefits because ultimately, the balances due are your responsibility.

• **INSURANCE BENEFITS:** It is your responsibility to verify benefits, know your deductible amounts and confirm that the doctor is a part of your plan or network.

• **INSURANCE CARD:** Please have this with you so that we can copy all of the necessary information from it. This will make the billing process easier for all of us. If your insurance should change, please notify the office as soon as possible.

• **COPAYS:** Please have your co-payment ready when checking in at the front desk. This is a contractual obligation with your insurance companies for which are responsible and it is mandatory that we collect it from you.

• **INSURANCE BENEFITS:** It is your responsibility to verify benefits and know your deductible amounts, however assistance is available if necessary.

• **WORKER'S COMP AND MOTOR VEHICLE ACCIDENTS :** We need to have your date of injury, claim number, case manager's name and telephone number before making an appointment.

Signature:_____ Date: _____

NAME: _____ DOB: _____