OFFICE USE ONLY VERIFIED (INITIALS)____

PATIENT REGISTRATION

PATIENT FULL NAME____Male___ Female___

ADDRESS____ HOME #__________________

CITY_______________________STATE_____ZIP________________CELL #___________________

PHARMACY/LOCATION_________________________________DATE OF BIRTH_____________

MARITAL STATUS: Single Married Widowed Separated Divorced Student (circle one)

PRIMARY CARE PHYSICIAN____

EMPLOYED BY_____________________________OCCUPATION___________________________

EMERGENCY CONTACT:

NAME____

RELATIONSHIP________________________________PHONE#_____________________________

INSURANCE INFORMATION:

PRIMARY INSURANCE:_________________________ID#_________________________________
HOLDER NAME:________________________DOB:______________RELATIONSHIP___________

SECONDARY INSURANCE:_______________________ID#_________________________________
HOLDER NAME:________________________DOB:______________RELATIONSHIP___________

TERTIARY INSURANCE:__________________________ID#_______________________________
HOLDER NAME:________________________DOB:______________RELATIONSHIP___________

IS THIS A WORKERS COMP INJURY? YES__NO__ (If so, please fill out Workers Comp form)

IS THIS DUE TO A MOTOR VEHICLE ACCIDENT? YES__NO__ (If so, please provide MVA Insurance Info)

REASON FOR VISIT____

LIST ANY MEDICAL CONDITIONS YOU HAVE____

PAST SURGICAL HISTORY____

LIST ALL MEDICATIONS YOU ARE TAKING____

LIST ALL ALLERGIES YOU HAVE (DRUGS, FOOD, OTHER)____

DO YOU HAVE HIGH BLOOD PRESSURE?________ **ARE YOU A DIABETIC?**_______ **ARE YOU A SMOKER?**______

AUTHORIZATION & RELEASE: I HEREBY AUTHORIZE THE RELEASE OF COPIES OF MY MEDICAL/PSYCHIATRIC/ALCOHOL/DRUG/HIV RELATED MEDICAL RECORDS AND NECESSARY INFORMATION TO MY INSURANCE COMPANIES & ANY PHYSICIAN PARTICIPATING IN MY MEDICAL CARE INCLUDING MEDICAL FACILITIES AND/OR HEALTH CARE AGENCIES. I CAN WITHDRAW THIS CONSENT AT ANY GIVEN TIME BY GIVING A WRITTEN NOTICE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED HERE TODAY INCLUDING CLAIMS THAT ARE PROCESSED INCORRECTLY DUE TO INACCURATE INFORMATION PROVIDED BY MYSELF ON THIS FORM. I AUTHORIZE ANY PROVIDER, OR THIRD PARTY BILLING WORKING WITH BRIAN P. DESCHAMPS, DPM TO FILE CLAIMS TO MY INSURANCE COMPANY, TO DEPOSIT CHECKS RECEIVED ON PATIENTS ACCOUNT WHEN MADE PAYABLE TO BRIAN P. DESCHAMPS, DPM OR ERIC M. THOMPSON, DPM. A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

____ ___________________________
Signed (Patient or Parent of Insured) Today's Date

BRIAN P. DESCHAMPS, DPM
ERIC M. THOMPSON, DPM, CWS
351 Merline Rd. Suite 101
Vernon, CT 06066
[covered entity]

Written Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name:____Date of Birth:_______________________

I, _____________________________, hereby acknowledge that I can request to review the office copy of the Notice of Privacy Acts (HIPAA) and understand that if I have further questions or concerns I may contact the office. I also understand that I am entitled to review upon request if the [covered entity's] Notice of Privacy Practices is amended or changed in a material way. I hereby grant Brian P. Deschamps, DPM and/or Eric M. Thomspon, DPM, CWS permission to contact the following persons regarding healthcare information necessary for my care:

1. ______________________________ ______________________________ ______________________
(NAME) (RELATIONSHIP) (PHONE NUMBER)

2. ______________________________ ______________________________ ______________________
(NAME) (RELATIONSHIP) (PHONE NUMBER)

3. ______________________________ ______________________________ ______________________
(NAME) (RELATIONSHIP) (PHONE NUMBER)

Signature:_______________________________________ Date:__________________________

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FOR OFFICE USE ONLY

An attempt was made to obtain written acknowledgment of review of the Notice of Privacy Practices from the above named patient, but was unable to because:

{ } Patient declined to sign the Written Acknowledgment
{ } Patient did not understand the request to sign the Written Acknowledgment
{ } Other:____

________________________________ ________________________________
(Name and Title of Employee) (Date)

BRIAN P. DESCHAMPS, DPM
ERIC M. THOMPSON, DPM, CWS
351 Merline Rd. Suite 101
Vernon, CT 06066

Appointment Cancellation Policy

Out of consideration for our patients needing an appointment, we ask that you kindly notify the office at least 24 hours in advance if you must cancel your appointment.

If you do not show up for a scheduled appointment or call 24 hours in advance you will incur a $45.00 charge posted to your account. This charge is NOT covered by your insurance.

I have received and understand this policy.

_________________________________ _________________________________

Patient Signature **Date**