

PAUL B. MURRAY, MD LLC
CONNECTICUT HAND AND ORTHOPEDICS, PLLC

Name: Guardian's Name:
Address: City: State: Zip Code:
SS #: DOB: Gender: Marital Status:
Home Phone #: Cell #: Work #:
Email Address:

Email is used solely for the purpose of accessing our Patient Portal. If you do not wish to receive an invitation to access your health information online, please sign here:

Please tell us how you heard about our office?

Preferred Language Race Ethnicity

HEALTH INSURANCE INFORMATION

Primary Insurance Policy Holder's Name
Policy Holder's DOB ID # Group #

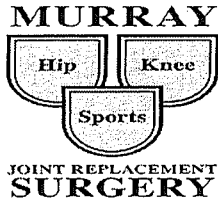
Secondary Insurance Policy Holder's Name
Policy Holder's DOB ID # Group #

INSURANCE ASSIGNMENT:

I request that payment of authorized Medicare Benefits/Commercial Insurance be made either to me or on my behalf to Paul B. Murray, MD LLC/Connecticut Hand and Orthopedics, PLLC for any services furnished me by that physician/supplier. I authorize and holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that if my insurance plan requires a referral for the doctor's examination and one is not obtained, payment becomes my responsibility.

SIGNATURE DATE

ALL CHARGES ARE DUE AT THE TIME OF SERVICE. THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION IF SURGERY IS INDICATED. THE PATIENT IS RESPONSIBLE FOR THE COST OF COLLECTIONS/COURT FEES AND REASONABLE LEGAL FEES IN THE EVENT OF NON-PAYMENT FOR MEDICAL SERVICES.



MEDICAL INFORMATION

Name: _____ Date: _____

Primary Care Physician: _____ Physician Address: _____

Referred By: _____

Pharmacy Name: _____ Height: _____ Weight: _____

Do you presently use tobacco products? _____ Have you ever used tobacco products? _____

If so, what type and how often/much? _____

Please place an "x" next to symptoms/medical conditions you have:

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Cough, Difficulty Breathing	<input type="checkbox"/> Fever or Chills
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Vomiting, Upset Stomach
<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Numbness or Weakness	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> STD
<input type="checkbox"/> Anemia	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer, Tumor	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Depression	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Ulcer, Stomach Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy, Seizures	<input type="checkbox"/> Stroke
<input type="checkbox"/> Alcoholism/Drug Abuse	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Other _____

List illnesses your blood relatives have had:

Relative: _____

Relative: _____

Relative: _____

HOSPITALIZATIONS/SURGERIES:

Approximate Date: _____

Approximate Date: _____

Approximate Date: _____

Approximate Date: _____

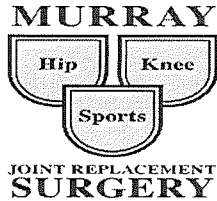
MEDICATIONS:

DOSAGE & FREQUENCY:

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

ARE YOU CURRENTLY IN A PAIN MANAGEMENT PROGRAM? _____

ALLERGIES: _____ / No Known Drug Allergies



CONSENT FORM FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date: _____

Date of Birth : _____ SS #: _____

DO YOU HAVE AN ADVANCED DIRECTIVE? _____YES _____NO

By signing this consent form, I understand that:

1. I am giving my consent to PAUL B. MURRAY, MD LLC or CONNECTICUT HAND AND ORTHOPEDICS, PLLC ("the Practice") for use and disclosure of the patient's identifiable health information for the following purposes and activities:
 - **Treatment** (including, but not limited to, disclosures necessary for consultations with and/or referrals to other providers, the coordination of the provision of care and the scheduling of care.)
 - **Payment** (including, but not limited to, disclosures necessary for obtaining payment for the provision of care, determining eligibility for coverage, billing and utilization review.)
 - **Health Care Operations** (including, but not limited to, disclosures necessary for conducting quality assessment and improvement programs, care coordination, evaluating provider performance, conducting provider training programs, all of which might be conducted by the Practice or by organizations that license, accredit, monitor or contract with the Practice as a network provider, business management and administrative activities of the Practice.)

2. The information disclosed may include information relating to the patient's:
 - Human immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS)
 - Treatment for or history of drug or alcohol abuse
 - Mental or behavioral health or psychiatric care

3. This consent will remain valid until it is revoked by me or by my duly authorized representative.

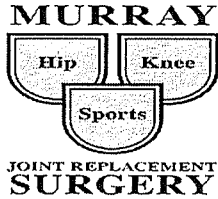
4. Paul B Murray MD, LLC or Connecticut Hand and Orthopedics, PLLC may leave a detailed message regarding my healthcare and treatment plan with:

Signature of patient or patient's representative: _____

Printed name of patient or patient's representative: _____

Relationship to patient: _____

Date: _____



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

{Paul B. Murray, M.D. LLC, 1000 Asylum Avenue – Suite 3220, Hartford, CT 06105}
{Connecticut Hand and Orthopedics, PLLC, 1000 Asylum Avenue – Suite 3220, Hartford, CT 06105}

Name of Patient: _____ Date: _____

I hereby acknowledge that I received a copy of this medical practice’s Notice of Privacy Practices. I further acknowledge that a copy of the current Notice will be posted in the reception area that that I may request a copy of any amended Notice of Privacy Practices at each appointment.

SIGNATURE _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate your relationship to the patient:

For Office Use Only:

- Signed form received by: _____
- Acknowledgement refused: _____
- Efforts to obtain: _____
- Reasons for refusal: _____