Welcome to New England Primary Care

We would like to thank you for choosing us as your health care provider. In order to make your visits more efficient, please read the following information, and complete the enclosed paperwork to the best of your abilities.

You must contact your insurance company and list New England Primary Care (Dr. Ian Tucker, Jennifer Para, APRN, or Olatunde Owoeye, APRN;) as your primary care provider. If you do not contact your insurance company, we may not be able to assist you in scheduling tests, referring you to specialists, or filling prescriptions. This is extremely important for our office and your health care.

Please bring your insurance card and photo ID to each office visit.

Location and hours:
55 Hazard Avenue, Enfield, CT 06082

Monday, Wednesday, Friday	8 a.m. to 6 p.m.
Tuesday and Thursday	10 a.m. to 8 p.m.
Saturday	9 a.m. to 3 p.m.

Arrival:
Please arrive on time for any and all office appointments. In order to provide quality care to all patients, we need to allow adequate time for each person to see the provider. Arriving late interferes with other patient appointment times, therefore compromising their care. If you are more than 10 minutes late for your appointment, you may be asked to reschedule and return on a different day.

Cancellation:
If you should need to cancel an appointment, please contact the office as soon as you are aware of it. A missed appointment will result in a “no show” charge. We require at least 24-hour notice if a cancellation is needed, please keep in mind that if you have an emergency and must cancel the day of, we will take that into consideration.

No-Show
Appointments are confirmed daily. No show appointments will result in a charge. If you have two “no-show” appointments during the same calendar year, you may be discharged from the practice.

Payment
Copays are due at the time of each visit. You will be billed if you do not supply your copay at your office visit.

Last Name: ___________________________________ First Name: ____________________________________

Sex: M F D.O.B. __________________ Email: ____

Address: ____ City: ______________ State: _____ Zip: ________

Home Phone: ______________________________ Cell Phone ______________________________

Marital Status: Married Single Divorced Legally Separated Widowed Partnered

List of household members (name/age):

____

____

____

____

Employer: ____________________________________ Occupation: ____

Insurance Information:

Primary Insurance: Secondary Insurance:

Insurance Co. Name: __________________________ Insurance Co. Name: ________________________

ID #: _______________________________________ ID #: _____________________________________

Group #: ____________________________________ Group #: _________________________________

Subscriber Name: _____________________________ Subscriber Name: __________________________

Subscriber D.O. B.: ____________________________ Subscriber D.O. B.: _________________________

Relationship to Subscriber: _____________________ Relationship to Subscriber: ___________________

Employer: ___________________________________ Employer: ________________________________

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.)? ____

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

____

____

Medication History:

CURRENT MEDICINES: List all medications – includes hormones, birth control pills, eye drops, vitamins, inhalers, creams, nasal sprays, supplements, and over the counter medicines ☐Check here if none

NAME OF MEDICATION	MILIGRAMS	TIMES PER DAY	NAME OF MEDICATION	MILIGRAMS	TMES PER DAY

Last Name: ______________________________ **First Name:** _________________________ **D.O.B.:** ___________________

Family History:

Please list which relative has had the medical problem.

If your mother (m), father (f), sister (s), brother (b), or children (c) have any of the following conditions

☐ I don't know my family history

☐ I am adopted

	Family Member		Family Member		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 Dancer		☐ Kidney Disease		☐ Thyroid Disease	
☐ COPD		☐ Learning Disabilities		☐ Transient Ischemic Attack	
☐ Crohn'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 birth control/contraception? ☐Yes ☐No

If yes what type? ______________________________

Do you have problems with sex or intercourse? ☐Yes ☐No

When was your last prostate screening? _________________

PSA: ______________ Exam: _____________________________

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 breast for lumps? ☐Yes ☐No

Date of last bone density test? ___________________

Date of last colonoscopy? ______________________

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?

____

____

Print Name: ______________________________ Signature: ____________________________ Date: ___________

Last Name: ______________________________ **First Name:** _________________________ **D.O.B.:** ___________________

Please record any **updates** or **changes** to your medical/surgical history below.

Medical Conditions: Have you ever had any of the following medical conditions? Check all that apply.

□ 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	

Any additional medical history:

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□ 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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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I, the undersigned, authorize **New England Primary Care** *to* RELEASE/OBTAIN *my health information as noted below:*

Name: Date of Birth:

I authorize **New England Primary Care** to: RELEASE my PHI ***to:***	I authorize **New England Primary Care** to: OBTAIN my PHI ***from:***
Name of Person or Agency: ______________________ ______________________	*Name of Person or Agency:* ______________________ ______________________
Address: ______________________ ______________________ ______________________	*Address:* ______________________ ______________________ ______________________
Phone: ______________________	*Phone:* ______________________

Dates of Treatment Covered by this Release:

❒ All prior dates of service/treatment, through discharge from present date of service/treatment

❒ Limited to the following date(s):

____

Information to be Released/Obtained

❒ All Records ❒ Progress Notes
❒ History/Physical ❒ Medication Reports
❒ Radiology Reports ❒ Consults Reports
❒ Lab Reports ❒ Discharge Summaries

Include: *(Indicate by initialing)*

_____________ Alcohol/Drug Treatment
_____________HIV Related Information
_____________Mental Health Information

Please Send Requested Information To:

❒ **New England Primary Care**
55 Hazard Avenue, Enfield, CT 06082
Fax: 860-744-2220

Expiration

❒ I do not want this authorization to expire.
❒ This authorization will expire on: ________________

STATEMENT OF ACKNOWLEDGEMENT

I understand that refusal to grant permission will in no way effect my right to obtain present and future treatment, except where disclosure of such communication and records is necessary for treatment. I further understand that the Confidentiality of psychiatric, drug and/or alcohol abuse and HIV records are protected under State and Federal law and cannot be disclosed without my written authorization unless otherwise provided for by law. I understand that I may make a request to inspect and/or copy the information to be used and that the agency will provide me with a copy of this signed authorization. The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal law.

Patient/Guarantor Signature: ____Date: __________________

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

New England Primary Care reserves the right to charge the following fees for missed ("no show") or cancelled appointments without a 24-hour advance notice absent of a compelling reason.

$50.00 for physical appointments

$25.00 for all other office appointments

Fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment.

Two "no shows" in any 12-month period may result in termination from out practice.

<u>By signing below, you acknowledge that you received this notice and understand this policy.</u>

____ _______________________________

Printed Name Date

____

Signature