Middlesex Health Primary Care
Adult New Patient Packet

Middlesex Health Primary Care

Dear New Patient,

We are pleased to welcome you as a patient of Middlesex Health Primary Care. Each and every day, the people at Middlesex Health Primary Care work to provide patient-centered, compassionate care to patients throughout our communities. We're proud of the association we have with one of the top hospitals in Connecticut, and we are confident that we can provide you with the best care possible. Thank you for choosing Middlesex Health Primary Care. We look forward to managing your health.

Sincerely,

Middlesex Health Primary Care

Patient Name: _____

First Appointment Date: _____
First Appointment Location: _____
First Appointment Provider Name: _____

Forms to Complete: **(We will accept and we appreciate completed forms prior to your visit)**

- □ Form 1: Authorization to Release Health Information (Used to obtain previous records)
- □ Form 2: Patient Information Form
- □ Form 3: Consent for Treatment/Release Information/Financial/HIPAA/Photo
- □ Form 4: Authorization to Disclose Health Information to Family & Friends
- □ Form 5: Health History Questionnaire (3 pages)

Please Bring the Following to your visit:

- □ Medical records (Complete and return Form 1 prior to first visit)
- □ Insurance card
- □ Required Co-Pay
- □ Completed patient forms (All 5 Forms)
- □ All medications you are currently taking, in original containers

Important Reminder: Please note that chronic pain management is not a core service of primary care and will not be routinely done at Middlesex Health Primary Care. If you have any questions about this, please feel free to contact our office.

Middlesex Health Primary Care

FORM 1

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name of Patient:	DOB:

I hereby authorize Middlesex Health Primary Care to release/obtain all medical information with respect to the treatment of the above referenced patient, including information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and /or confidential HIV related information.

Release the Medical Records From:

Method: ☐ Mail ☐ Pick up ☐ Fax

Medical Group Name:_____

Address: _____

City: _____State: _____ Zip:_____

Fax: (If needed):_____

Phone: _____

Send the Medical Records To:

Method: ☐ Mail ☐ Pick up ☐ Fax

Name:_____

Address: _____

City: _____State: _____ Zip:_____

Fax: (If needed):_____

Phone: _____

What is the Purpose of Health Information Release?

☐ Personal	☐ New Physician	☐ Social Security Disability	☐ Other: _____
☐ Primary Care Physician	☐ Medical Ins. Claim	☐ Life Insurance	
☐ Consultation	☐ Worker's Comp	☐ Attorney	

Describe the Health Information to be released:

Service Dates: from:_____to:_____Information Needed By: _____

☐ Complete Medical Record	☐ Other: _____		
☐ History and Physical	☐ EKG's	☐ Laboratory Results	☐ Hospital Notes
☐ Immunization Records	☐ Pathology Reports	☐ Radiology Reports	☐ Clinic Notes
☐ Hospital Discharge Summary	☐ Operative Reports	☐ Radiology Images	☐ Billing Information

I understand that Middlesex Health Primary Care will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization. I understand that I may revoke this Authorization at any time by providing written notice to Middlesex Health Primary Care. I understand that I may not be able to revoke this Authorization if Middlesex Hospital Primary Care has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.

I understand that the Protected Health Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy Regulations.

I also understand that if the Protected Health Information that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may not re-disclose that information under Connecticut State Law.

This Authorization will expire one year from the date of signing unless I indicate an earlier date or event here:_____

Date: **Signature of Patient or Person granting Authorization on behalf of patient**

Printed Name of Person Signing (If Not the Patient) **Relationship to Patient**

Middlesex Health Primary Care

FORM 1 (page 2)

NOTICE

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist-patient communications:

> "The confidentiality of this record is required under chapter 899 of Connecticut General Statutes. This material shall not be transmitted to anyone without the written consent or other authorization as provided in the aforementioned statutes." (§ 52-146i)

Drugs and Alcohol Abuse Records

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

> "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." (42 C.F.R. § 2.32)

HIV Related Information

In the event that information released constitutes confidential HIV related information protected under Connecticut Law:

> "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose." Conn. Gen. Stat. 19a-585(a)

Middlesex Health
Primary Care

Form 2: PATIENT INFORMATION

Demographics

Last Name: First Name: Middle:

Preferred Name: Suffix: Date of Birth:

Address: Mailing Address:

City: State: Zip:

Legal Sex: □ Male □ Female □ Nonbinary □ X

Sex Assigned at Birth: □ Male □ Female □ Unknown

Gender Identify: □ Male □ Female □ Transgender Female (M to F) □ Transgender Male (F to M) □ Other

Preferred Pronouns: □ she/her/hers □ he/him/his □ they/them/theirs □ Preferred Name (as above) □ Decline to answer

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnered

Contact Information

Home Phone: Cell Phone: Work Phone:

Appointment Reminder Preference: (choose one) □ Home OR □ Cell If Cell: □ Voice OR □ Text

Personal Email Address for Patient Portal Use:

Emergency Contact Name: Emergency Contact Phone:

Relation to You:

Pharmacy / Lab Preference/Insurance Information

Local Pharmacy Name: Local Pharmacy Address:

Mail Order Pharmacy: Mail Order Pharmacy Address:

Preferred Lab:

Insurance Information: *Please bring your insurance card to each visit*

Additional Information

Race: □White □ Hispanic □ Black-African American
□ Asian □ American Indian □ Native Hawaiian
□ Other Pacific Islander □ Unreported/Refused to Report □ Other Race

Ethnicity: □ Hispanic □ Non-Hispanic □ Refused to Report

Preferred Language: □ English □ Spanish □ Other:

Employer: Occupation:

FORM 3: Consent for Treatment, Authorization for Release of Information, Financial Agreement and Consent for Photo ID

PRINT NAME: _____ **DOB**: _____

CONSENT FOR TREATMENT:
Permission is hereby given to the physicians and staff of Middlesex Health Primary Care ("MHPC"), a Middlesex Health System affiliate, to provide ordinary and necessary medical examination, diagnosis and treatment and administer such therapeutic treatment or services that the physician may order. Ordinary and necessary medical care shall include preventive and prophylactic care as well as laboratory tests, but shall not include surgery, general anesthesia, laboratory tests for which separate consent is required under the law or other extraordinary procedures. I further consent to routine immunizations for future office visits.

AUTHORIZATION FOR RELEASE OF INFORMATION:
I acknowledge that my health information, including information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV-related information, may be disclosed in accordance with law. I also understand that my health information may be maintained in an electronic health information exchange network or other electronic database, released to and accessible to all providers involved in my care regardless of their location, hospital-affiliation or specialty, and that my Middlesex Health System providers may have access to this information from other providers. I understand that this information may include my prescription history. Finally, I understand that I may be contacted by MHPC or its business associates at the primary phone number that I provided, which may be my cell phone, via phone call and/or text message, for purposes of treatment, appointment reminders and/or payment of my bills.

I specifically authorize the release of any and all information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV related information to any person or organization involved in my care or treatment and/or to any organization responsible for payment of services furnished to me. In the event that any of the foregoing information is released, I understand that state and federal law prohibits further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by state and federal law. Withdrawal of this authorization shall be addressed in writing to the Director of Health Information Management at Middlesex Health. I understand that neither MHPC nor any of its related entities or providers will condition treatment, payment, enrollment or eligibility for benefits on this authorization to release information.

FINANCIAL AGREEMENT/ASSIGNMENT OF INSURANCE BENEFITS:
I understand that I am obligated to pay MHPC for services provided to me in accordance with the rates and terms of MHPC, including a "No-Show" fee of **$45 for a missed office visit and $75 for a missed comprehensive physical exam or surgical procedure appointment** if I fail to appear and did not cancel at least 24 hours in advance. In consideration for services provided or to be provided to me, I hereby assign to MHPC all basic and major medical or other insurance benefits, including, without limitation, Medicare or Medicaid benefits, to cover such expenses. In connection with such assignment, MHPC is hereby authorized to contact my insurance carrier on my behalf and to obtain any and all such information (including, without limitation, copies of any plans, contract, or other documents defining or otherwise limiting the scope of insurance coverage by such carrier) as may be necessary to process any insurance claims related to my treatment by MHPC. If I am not insured, I hereby authorize MHPC to use and/or disclose my health information in order to obtain funds to cover expenses related to my treatment by MHPC. I owe and agree to pay MHPC for any and all charges not actually paid by insurance benefits, including those charges not covered by my insurance policy and those charges that my insurance company deems to be experimental or medically unnecessary. If my account is not paid, I will pay all court costs, attorney's fees and other costs incurred by MHPC to collect the balance owed. I also authorize payment directly to MHPC or the entity providing service under the above account number that would otherwise be payable to me.

HIPAA ACKNOWLEDGEMENT:
The undersigned hereby acknowledges that I have received a copy of the Middlesex Health System Joint Notice of Privacy Policy.

CONSENT FOR PHOTO IDENTIFICATION:
I consent to MHPC taking a digital photograph of my face for purposes of patient identification. The digital photograph will remain with my electronic medical chart and will not be used for other purposes without my authorization.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, UNDERSTOOD AND AGREED TO THE FOREGOING, AND IS THE PATIENT OR HIS/HER REPRESENTATIVE.

_____

Date Signature of Patient or Person Granting Authorization on Behalf of Patient

If the patient has not signed this form, please print the signer's name, relationship to the patient and, if necessary, explain why the patient did not sign.

Middlesex Health

Form 4

Outpatient Services / Office Visits
Patient Record of Disclosures
Notification of Disclosures to Persons Involved in Your Care

(This form may be used for all other hospital services and Off-site Locations.)

Patient Name:_____ **DOB:**_____

Permission to disclose information by telephone or by mail:

☐ No, I do not wish to have information via phone message or written communication.

☐ Yes, I wish to be contacted in the following manner:

Home #:	Work #:	Cellphone #:
☐ Leave a message with detailed information ☐ Leave a message with the call-back number only	☐ Leave a message with detailed information ☐ Leave a message with the call-back number only	☐ Leave a message with detailed information ☐ Leave a message with the call-back number only

☐ Written Communication
- ☐ Mail to my home address:_____
- ☐ Mail to my work/office address:_____
- ☐ Fax to this number:_____

☐ Other:_____

Permission to disclose information to family or other persons involved in your care

Unless you specifically agree, we will not disclose any information to family or other persons involved in your care either by phone or in person. This means, for example, that we will not be able to answer questions about a prescription, bill, schedule appointments or otherwise discuss your care or treatment with anyone other than you.

☐ No, I do not wish to have information shared with family or other persons involved in my care.

☐ Yes, I would like MHS to be able to discuss information related to my care with specific persons, listed below:

Name	Phone number	Relationship to Patient

_____ _____ _____
Signature of Patient or Personal Representative | Date | Time

_____
Relationship to Patient

FORM 5: MHPC – Health History Questionnaire

Name: _____ Preferred Name: _____ DOB: _____

Current Concerns: ❑ No concerns ❑ Establish care with a new Primary Care Provider

1._____ 3._____
2._____ 4._____

Past Health History:

Have you had any of the following medical conditions?

- ❑ Acid reflux / Heartburn
- ❑ Anemia (low blood count)
- ❑ Anxiety / Panic attacks
- ❑ Arthritis (Location: _____)
- ❑ Asthma
- ❑ Blood clotting problems
- ❑ Bone fracture (Location: _____)
- ❑ Cancer (Type: _____)
- ❑ Cataracts
- ❑ Chronic pain (Location: _____)
- ❑ Concussion / Head injury
- ❑ Constipation
- ❑ COPD / Emphysema
- ❑ Dementia / Alzheimer's
- ❑ Depression
- ❑ Diabetes / High blood sugar
- ❑ Erectile dysfunction
- ❑ Fibromyalgia
- ❑ Glaucoma
- ❑ Gout
- ❑ Gynecological problems (Explain: _____)
- ❑ Hearing loss
- ❑ Heart disease / Heart attack
- ❑ Heart Failure
- ❑ Heart murmur
- ❑ Hemorrhoids
- ❑ Hernia (Location: _____)
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heart beat / Palpitations
- ❑ Joint problems (Location:_____)
- ❑ Kidney problems (Explain:_____)
- ❑ Liver problems
- ❑ Migraine / Frequent headaches
- ❑ Mobility problems
- ❑ Osteoporosis
- ❑ Prostate problems
- ❑ Seasonal allergies
- ❑ Seizures
- ❑ Sexually transmitted infection
- ❑ Skin condition (Explain: _____)
- ❑ Sleep apnea
- ❑ Stomach / GI problems (Explain: _____)
- ❑ Stroke / TIA
- ❑ Substance or alcohol abuse
- ❑ Transgender / Gender noncomforming
- ❑ Thyroid problems
- ❑ Urinary incontinence
- ❑ Urinary tract infections
- ❑ Other:_____
- ❑ Other:_____

Have you had any of the following surgeries?

- ❑ Appendectomy
- ❑ Back surgery (Location: _____)
- ❑ Biopsy (Location: _____)
- ❑ Breast surgery
- ❑ Carotid artery surgery
- ❑ Cataract surgery
- ❑ Colon surgery (Type: _____)
- ❑ C-Section(s)
- ❑ Dilation & Curettage (D&C)
- ❑ Ear tubes
- ❑ Gallbladder removal
- ❑ Gastric bypass / Weight loss surgery
- ❑ Heart bypass
- ❑ Heart stent(s)
- ❑ Hemorrhoid surgery
- ❑ Hernia repair (Location: _____)
- ❑ Hysterectomy
- ❑ Joint replacement(s) (Location:_____)
- ❑ Pacemaker insertion
- ❑ Prostate surgery
- ❑ Tonsillectomy
- ❑ Other:_____

Prior Hospitalizations: *Please include year and reason*

_____
_____

List Health Care providers involved in your care: *(Example Dr. Jones - Cardiology)*

_____ _____ _____
_____ _____ _____

Allergies: *Please include name of medication or food and type of reaction*

Name	Reaction	Name	Reaction
1)		3)	
2)		4)	

Name: _____ DOB: _____

Current Medications: *Please include prescription medications, over-the-counter drugs, vitamins and supplements*

Name / Dose	# Tabs / Frequency	Name / Dose	# Tabs / Frequency
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Family History: *Please indicate if any of the following conditions are present in your family members*

Relative	**Status**	**Cancer** (Specify Type)	**Diabetes**	**Heart Disease**	**High Blood Pressure**	**Mental Illness** (Specify)	**Stroke**	**Other** (ex: dementia, thyroid disease)
Father	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Paternal Grandfather	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Paternal Grandmother	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Paternal Other_____	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Mother	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Maternal Grandfather	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Maternal Grandmother	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Maternal Other_____	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Siblings _____	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Children _____	☐ Alive ☐ Deceased		☐	☐	☐		☐	

Social History:

Highest level of Education: _____ Location of Birth: _____

Occupation: _____ Occupational/Environmental Exposures: _____

Marital status: ❑ Single ❑ Married ❑ Divorced / Separated ❑ Widowed ❑ In a relationship

Past sexual history: *(check all that apply)* ❑ Male partners ❑ Female partners ❑ Multiple partners

Current sexual history: *(check all that apply)* ❑ Male partners ❑ Female partners ❑ Multiple partners ❑ Not Active

Do you feel safe with your partner? ❑ No ❑ Yes ❑ Not Applicable

Do you feel safe at home? ❑ No ❑ Yes Who do you live with? _____

Do you have a case manager or social worker? ❑ No ❑ Yes (provide name / phone #:_____)

Alcohol use: ❑ None ❑ Yes (# of drinks / day: _____, # of drinks / week: _____)

Tobacco use: ❑ Never ❑ Former (Quit Date: _____) ❑ Current (# of cigs / day:_____) ❑ E-cigs / Vape / Chew

Recreational drugs: ❑ None ❑ History of injection drug use ❑ Past / Current use (Explain: _____)

Diet: ❑ Diabetic ❑ Heart Healthy ❑ "Meat & Potatoes" ❑ Mediterranean ❑ Vegetarian ❑ Other_____

Name: _____ DOB: _____

Social History Continued:

Do you exercise regularly? ❑ No ❑ Yes (What type and how often?_____)

Have you fallen in the past year? ❑ No ❑ Yes

Have you traveled outside the U.S. in the past 5 years? ❑ No ❑ Yes (Where? _____)

Do you have an Advanced Directive or Living Will? ❑ No ❑ Yes *(if yes, please make sure we receive a copy)*

Code status: ❑ Full Code ❑ Do Not Resuscitate ❑ Do Not Resuscitate / Do Not Intubate ❑ Unknown

Preventive Health History: *Please indicate the date the following were performed*

	Date		Date
Last wellness visit / Complete physical		Stress test	
Breast cancer screening (Mammogram)		Hepatitis C screening (if born 1945-1965)	
Cervical cancer screening (Pap smear, HPV test)		Flu Vaccine	
Colon cancer screening (Colonoscopy, Cologuard)		Pneumonia Vaccine	
Lung cancer screening (CT scan for high risk only)		Shingles Vaccine	
Osteoporosis screening (Bone density)		Tetanus / TDAP Vaccine	

Review of Systems: *Please check the box if you have experienced any of the following symptoms in the* ***past 4 weeks***

GENERAL
Weight gain or loss over l0 pounds ❑
More fatigue than usual ❑
Fever, chills, or night sweats ❑

SKIN
Changes in your skin, hair, or nails ❑
Dryness or itching ❑
Rashes ❑
Jaundice or yellowing of the skin ❑
Moles that have changed in appearance ❑

HEAD
Headaches ❑
Head injuries ❑

EYES
Trouble with your vision ❑
Eyeglasses/contact lenses ❑
Eye pain, redness, or excessive tearing ❑
Double vision ❑

EARS
Trouble with hearing ❑
Pain in ear ❑
Discharge (fluid) from ear ❑
Ringing in ears ❑
Spinning or vertigo attacks ❑

NOSE/SINUSES
Face or sinus pressure ❑
Postnasal drip ❑
Nasal congestion ❑
Nosebleeds ❑

MOUTH/THROAT
Recent change in taste ❑
Bleeding of gums, mouth, or throat ❑
Sore throat or hoarse voice ❑

NECK
Swollen glands or lumps ❑
Neck pain or stiffness ❑

BREAST
Breast lumps or bumps ❑
Discharge from the nipple ❑
Pain in the breast ❑

CARDIOVASCULAR
Swelling in legs or feet ❑
Difficult or uncomfortable breathing ❑
Needing to sleep upright to breathe better ❑
Chest pain, pressure, or tightness ❑
Racing, pounding, or irregular heart beat ❑

RESPIRATORY
Wheezing ❑
Chronic or frequent cough ❑
Coughing up phlegm (mucus) ❑
Coughing up blood ❑
Exposure to someone with Tuberculosis ❑

GASTROINTESTINAL
Trouble/pain with swallowing ❑
Frequent Heartburn ❑
Pain after eating ❑
Abdominal pain/discomfort ❑
Nausea/vomiting ❑
Vomiting up blood ❑
Changes in bowel habits ❑
Constipation ❑
Diarrhea ❑
Unusual colored stools ❑
Bleeding from rectum ❑

GENITOURINARY
Difficulty passing urine ❑
Frequent urination ❑
Urinating more than once at night ❑
Any pain, burning, or odor to urine ❑
Leak urine or wet yourself ❑
Urine appeared bloody or reddish ❑
Groin pain / bulge with lifting or straining ❑

REPRODUCTIVE
Sores on or discharge from the penis ❑
Lump on the testicle ❑
Pain in the testicles ❑
Sores on or discharge from the vagina ❑
Menstrual cycle irregularities ❑
Unexpected vaginal bleeding ❑
Vaginal pain, dryness, itchiness, or odor ❑

SEXUAL HEALTH
Interested in getting pregnant ❑
Not using any contraception ❑
Concern for sexually transmitted infection ❑
Problems/concerns about sexual function ❑
Had an unwanted sexual experience ❑

PERIPHERAL VASCULAR
Pain or numbness in legs while walking ❑
Fingertips change color when cold ❑
Varicose Veins ❑

MUSCULOSKELETAL
Joint pain ❑
Swelling, redness, or warmth in joints ❑
Back pain or stiffness ❑
Weakness in muscle(s) ❑

NEUROLOGICAL
Dizzy spells or lightheadedness ❑
Convulsions or seizures ❑
Loss of consciousness/ fainting ❑
Any speech problems ❑
Trouble staying awake ❑
Problems with memory ❑
Numbness or tingling in hands or feet ❑
Weakness in particular part of body ❑
Trouble with sleep ❑

HEMATOLOGICAL
Bleed or bruise easily ❑
Received any blood transfusions ❑

ENDOCRINE
Do you ever feel too hot or too cold ❑
Excessive thirst ❑

BEHAVIORAL HEALTH
Seen a counselor, therapist, or psychiatrist ❑
Experience mood swings ❑
Feel depressed ❑
Loss of interest or pleasure in things ❑
Thoughts of self harm or suicide ❑
Previous suicide attempt ❑
Feel frequently worried or nervous ❑
Feel you should cut down on drinking ❑

Reviewed by Primary Care Provider: _____ Date: _____