

Colon & Rectal Surgeons of Greater Hartford, LLC

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Pt. No. _____

Patients Name _____ Sex M/F _____ Marital Status _____ Age _____

Address _____ Date of Birth _____

City _____ State _____ Home Phone# _____

Zip Code _____ S.S.# _____ Cell Phone # _____

Employer Name _____ Work Phone# _____ Ext. _____

Employer's Address _____ Occupation _____

Referring Doctor _____ Primary Doctor _____

Nearest Relative (not living with you) _____ Phone # _____

Primary Insurance Company _____

Name of Insured _____ Relationship _____

Date of Birth _____ Employer's name _____

Insurance I.D. # _____ Policy/Group # _____

Secondary Insurance Company _____

Name of Insured _____ Relationship _____

Date of Birth _____ Employer's name _____

Insurance I.D. # _____ Policy/Group # _____

Comments _____

MEDICAL HISTORY

Previous Surgery: _____

Do you have any history of disease of the heart, lungs, kidney, high blood pressure? _____

_____ If yes, please explain: _____

Do you have family history of heart disease, cancer, or diabetes? _____

If yes, please explain _____

Are you taking any medications now? (please specify) _____

Are you allergic to any medications? _____

AUTHORIZATION AND RELEASE: I hereby authorize release of any medical information necessary to process my insurance claim, and request payment of medical benefits be made directly to **COLON & RECTAL SURGEONS OF GREATER HARTFORD** for services rendered to me by the above named physician and/or physician group.

I understand that any amount deemed by my insurance carrier to be beyond the "usual, reasonable and/or customary" charges for said services will be paid by me. I recognize and accept personal responsibility for immediate payment of charges not covered by my contract and agree to pay attorney's fees, court costs, and any other responsible costs of collection should I fail to make payment

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Colon and Rectal Surgeons of Greater Hartford, LLC
6 Northwestern Drive Suite #305 Bloomfield, CT 06002
2400 Tamarack Road South Windsor, CT 06074
58 West Main Street, Plainville, CT 06062

Practice Manager, Privacy Official 860-242-8591 X116

Name of Patient: _____

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, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Phone: _____

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:

Reason for refusal:



Dear Patient,

Our office currently submits most prescriptions electronically. Please complete the following information with your preferred pharmacy, and check off the appropriate physician so we may expedite the process of prescriptions ordered by our practice.

Name: _____

- Saumitra R. Banerjee, MD
- Steven H. Brown, MD
- David A. Cherry, MD
- William P. Pennoyer, MD
- David L. Walters, MD
- Ly C. Tran, PA-C

Pharmacy Name _____
Pharmacy Address _____
Pharmacy City _____
Pharmacy Phone _____

Colon and Rectal Surgeons of Greater Hartford, LLC
Allergy Record

Patient Name: _____ Account # _____

Please note the drug or non-drug you are allergic to.

Allergy: _____

Symptoms: **(Please circle either yes or no if symptoms occur)**

Skin Rashes/Hives	Yes / No
Nausea/Vomiting/Diarrhea	Yes / No
Shock/Unconsciousness	Yes / No
Anemia/Blood Disorder	Yes / No
Asthma/Shortness of Breath	Yes / No

Specific

Description: _____

Please note the drug or non-drug you are allergic to.

Allergy: _____

Symptoms: **(Please circle either yes or no if symptoms occur)**

Skin Rashes/Hives	Yes / No
Nausea/Vomiting/Diarrhea	Yes / No
Shock/Unconsciousness	Yes / No
Anemia/Blood Disorder	Yes / No
Asthma/Shortness of Breath	Yes / No

Specific

Description: _____

Please note the drug or non-drug you are allergic to.

Allergy: _____

Symptoms: **(Please circle either yes or no if symptoms occur)**

Skin Rashes/Hives	Yes / No
Nausea/Vomiting/Diarrhea	Yes / No
Shock/Unconsciousness	Yes / No
Anemia/Blood Disorder	Yes / No
Asthma/Shortness of Breath	Yes / No

Specific

Description: _____

Patient

Signature: _____ Date: _____