# PBK PRIMARY CARE, 27 HOSPITAL AVENUE, SUITE 403, DANBURY, CT

## DEMOGRAPHICS

Reason for visit: _____

Last Name: _____

First Name: _____

DOB: _____ Gender: ❑Male ❑Female

Address _____

City _____ State _____ Zip _____

Home # (  ) _____ Cell # (  ) _____

Work # (  ) _____ Other # (  ) _____

Preferred Phone: ❑Home ❑Cell ❑Work ❑Other

Email: _____

Preferred Language: ❑English ❑Spanish ❑Other

Race: ❑Caucasian ❑African American ❑Asian ❑Other

Ethnicity: ❑Hispanic ❑Non-Hispanic Marital status: S❑M❑D❑W❑

Primary Care Physician: _____

Emergency Contact: _____

Ph #: (  ) _____ Relationship _____

Preferred Pharmacy(Name, location) _____

_____

## INSURANCE

### Primary Insurance

Insurance Coverage: ❑ Yes ❑No

Insurance Company: _____

ID #: _____ Group # _____

Subscriber last name: _____ First: _____

DOB: _____ Gender: ❑Male ❑Female

Relationship to patient: _____

### *Secondary Insurance*

Secondary Coverage: ❑ Yes ❑No

Insurance Company: _____

ID #: _____ Group # _____

Subscriber last name: _____ First: _____

DOB: _____ Gender: ❑Male ❑Female

Relationship to patient: _____

**Payment is due in full at time of treatment unless prior arrangements have been approved.**

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment/deductibles that my insurance does not cover. I understand that I am responsible for all cost of medical treatment. I hereby authorize release or any information, including the diagnosis and records or treatment/exam rendered, to my insurance company.

Signature: _____ Date: _____

## MEDICAL HISTORY

❑Non-Contributory

❑Acid reflux ❑Anemia ❑Cancer(type) _____

❑Heart disease ❑Depression ❑Diabetes

❑High blood pressure ❑High cholesterol ❑HIV/AIDS

❑Thyroid disease ❑Other _____

## SURGICAL HISTORY

❑Non-Contributory

| Surgery Type: | Date: |
|---|---|
| | |
| | |
| | |
| | |

## CURRENT MEDICATION

❑Non-Contributory

❑List attached

| Drug: | Dosage: |
|---|---|
| | |
| | |
| | |
| | |
| | |

## ALLERGIES

❑Non-Contributory

Medication allergies:

| | |
|---|---|
| | |
| | |
| | |

Other allergies:

| | |
|---|---|
| | |

## SOCIAL HISTORY

❑Non-Contributory

Occupation _____ ❑FT ❑PT

Smoker ❑ Yes ❑No # packs per day _____

Alcohol ❑ Yes ❑No # per week _____

Substance abuse ❑ Yes ❑No

## FAMILY HISTORY

❑Non-Contributory

❑Acid reflux ❑Anemia ❑Cancer ❑Heart disease

❑Depression ❑Diabetes ❑High blood pressure

❑High cholesterol ❑Other:

_____

# Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of the Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of PBK Primary Care health care operations. The Notice of Privacy Practices also describes my rights and PBK Primary Care duties with respect to my protected health information. The Notice of Privacy Practices is posted in the front office.

PBK Primary Care reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy of the Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Relationship or Personal Representative (if applicable)

_____

I, _____, give PBK Primary Care permission to speak to _____ in regards to my medical history and treatment.

_____

Patient Signature and Date

_____

Signature of Staff and Date

# PBK PRIMARY CARE

27 HOSPITAL AVENUE, SUITE 403
DANBURY, CT 06810

## WAIVER FOR SERVICES NOT COVERED

**Patient Name:**_____ **DOB:**_____

**I, _____, understand that services provided today may not be covered by my insurance carrier, for which I am responsible, for the following reason(s):**

**__x__The service provided may not be a covered benefit**

**__x__The provider is not listed as my Primary Care Physician**

**__x__The visit falls outside the insurance company's allowed frequency**

**__x__No insurance card presented at the office for verification**

**__x__New insurance, no card available**

**__x__Insurance is ineligible for today's date of service**

****Please note that any request for medical records will be charged at the rate of $.45/page plus postage. No records will be sent out without payment being received by this office.**

_____ **Date:**_____

**(Patient's Signature)**

# PBK PRIMARY CARE

27 HOSPTIAL AVENUE, SUITE 403, DANBURY, CT 06810
PHONE: (203) 244-9529 FAX: (203) 355-7147

**I,_____ DOB_____ give permission for release of my medical information from/to PBK Primary Care. This information requested is (check off the following that apply).**

___ Office Notes
___ Problem List
___ Immunization records
___ Lab and test results
___ Recent Physical and EKG
___ Other (specify below)

---

This information can be mailed or faxed to:

Name:_____

Address:_____

City, State, Zip Code:_____

Phone & Fax:_____

---

Patients Signature: _____
Date: _____

Get medical records from:
Doctors Office: _____
Address: _____
Phone: _____
Fax: _____