Comprehensive Medical Care of Danbury

27 Hospital Avenue
Suite 403
Danbury, CT 06810
www.cmcdanbury.com
203-730-2900

Important Patient Information

Arrive Early
We respectfully request that you arrive 10 minutes prior to your scheduled appointment time so that we may update your records and insurance information. Please alert the receptionist if address or insurance information has changed since your last visit. Please be aware that it is the patient's responsibility to ensure that we have current information.

Late Arrivals
If you are late for your appointment, please be aware that you may be asked to reschedule that appointment in an effort to prevent delaying other patients who have arrived on time.

Rescheduling Appointments
If you are unable to keep your scheduled appointment, you must give us 24 hours' notice to allow another patient to fill that appointment time.

Missed Appointment: As of February 1, 2014
If you fail to keep your appointment or if you cancel with less than 24 hours' notice, you may be charged a $ 25.00 fee for regular visit or $ 50.00 fee for physical/ procedure. This is not covered by insurance.

Available Tests/ Procedures in office:

1. Physicals
2. School Physicals
3. Pre-Operative Medical Clearance
4. Worker's Compensation (Please always notify staff before visit If WC related)
5. Cardiac Holter- 24 hour + EKG
6. Ambulatory Blood pressure Monitoring
7. Overnight Pulse Oximetry- Sleep Apnea
8. Hearing Testing- Audiometry and Oto-Acoustic-Emmision
9. Bladder Scan and Uroflowmetry- Incontinence Assessment
10. Spirometry and Pulmonary Function Testing
11. Arterial Doppler- Peripheral Arterial Disease
12. Minor Surgery and Laceration Repairs
13. HgA1C, Micro-albumin and other Diabetes Testing
14. Cortisone Joints' injection
15. Medical Aesthetics

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Patient Registration

Patient Name:	Patient Date of Birth:	Today's visit date:
Home Address:	City:	State and Zip Code:
Employer:	Occupation:	Marital Status:
Patient Social Security #:	Patient Drivers License #:	Home Phone Number:
Patient Work Phone: ( ) - Patient Cell Phone: ( ) -	Spouses name, if applicable:	Phone Number for spouse: ( ) -
Emergency Contact Name:	Phone Number for Emergency Contact: ( ) -	Address for Emergency Contact:
Billing Name (if different than above)	Billing address (if different than above)	Relationship to patient
Primary Health Insurance Company Name:	Address:	Policy Number:
Name of Insurance Holder	Relationship to Patient	Group Number:
Secondary Health Insurance Company Name, if applicable:	Address:	Policy Number:
Email:		

AUTHORIZATION TO PROVIDE MEDICAL HEALTH SERVICES

I authorize my doctor to diagnose, treat and provide me with medical and healthcare services and I further agree to treatment plans.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Taweh to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. Taweh for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

POLICY FOR MISSED APPOINTMENTS

I understand that there will be a "NO SHOW" fee for missed appointments that are not cancelled at least 24 hours in advance($ 25 for regular visit/ $ 50 for physicals/ prolonged service)

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request.
I request that payment of authorized benefits be made on my behalf.
A photocopy of the assignments shall be valid as the original.

PATIENT OR PARENT/GUARDIAN NAME:	PATIENT OR PARENT/GUARDIAN SIGNATURE:

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MEDICAL HISTORY

Name:
Today's Date:
Date of Birth:
Sex: Male/ Female

Drug Allergies	Medical/ Mental Problems		Medications	
1.	1.	4.	1.	4.
2.	2.	5.	2.	5.
3.	3.	6.	3.	6.

Medical History

☐ Abdominal Pain – Chronic	☐ Gall Bladder Trouble	☐ Pneumonia	☐ Chicken Pox ☐ Polio ☐ Mumps
☐ Allergies/Hayfever	☐ Gout	☐ Prostate Disease	☐ Measles ☐ Rubella
☐ Anemia	☐ Hair Loss	☐ Psoriasis ☐ Eczema	☐ Rheumatic Fever
☐ Ankles – Swollen	☐ Headaches – Frequent	☐ Rashes ☐ Hives	☐ Scarlet Fever ☐ Tuberculosis
☐ Appetite – Loss of	☐ Heart Murmur	☐ Sexual/Menstrual Dysfunction	☐ Herpes
☐ Arthritis/Rheumatism	☐ Hemorrhoids	☐ Sinus Trouble	☐ Other:
☐ Asthma/Wheezing	☐ Hernia	☐ Stools – Bloody or Tarry	**FEMALES** – *Please Complete*
☐ Back Pain – Recurrent	☐ High Blood Pressure	☐ Stroke	Pregnant? ☐ Yes ☐ No
☐ Bone Fracture/Joint Injury	☐ Indigestion or Heartburn	☐ Swallowing Difficulty	Planning Pregnancy? ☐ Yes ☐ No
☐ Bowel Habits – Change in	☐ Infections – Frequent	☐ Tetanus	Menstrual Flow:
☐ Bronchitis/Chronic Cough	☐ Jaundice/Hepatitis	☐ Throat – Sore – Frequent	☐ Regular ☐ Irregular ☐ Pain / Cramps
☐ Cancer	☐ Kidney Stones	☐ Thyroid Disease	Days of flow Length of Cycle
☐ Chest Pain	☐ Lactose Intolerance	☐ Tremor / Hands Shaking	Date – 1st day of last period:
☐ Convulsions/Seizures	☐ Leg Pain - Walking	☐ Ulcers - Peptic	☐ Pain/Bleeding during or after sex.
☐ Diabetes	☐ Memory Loss	☐ Urethral Discharge	Number of:
☐ Diarrhea ☐ Constipation	☐ Mental Illness	☐ Urination-☐Overnight>Than Twice	Pregnancies Abortions
☐ Diphtheria	☐ Moodiness - Excessive	☐ Decrease in Force/Flow	Miscarriages Live Births
☐ Diverticulosis ☐ Crohn's/Colitis	☐ Muscle Weakness	☐ Painful ☐ Loss of Control	Birth Control Method
☐ Dizziness/Fainting	☐ Nausea/Vomiting – Persistent	☐ Urine – Blood in	B.C. Pill (Name):
☐ Ear Infections – Frequent	☐ Nervousness ☐ Depression	☐ Varicose Veins/Phlebitis	☐ Flushing/Menopause
☐ Ear – Ringing In	☐ Nose Bleeds	☐ Venereal Disease	Date of Last PAP Test
☐ Eye Infections	☐ Numbness/Tingling Sensations	☐ Vision - Failing	☐ Normal ☐ Abnormal
☐ Fatigue - Chronic	☐ Osteoporosis	☐ Weight Loss	Date of Last Mammogram
☐ Foot Pain ☐ Cold Numb Feet	☐ Phobias		☐ Normal ☐ Abnormal

Family History

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents		Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	Kidney Disease	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	Mental Illness	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	Migraine	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐	Stroke	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	Thyroid Disease	☐	☐	☐	☐	☐	☐
Hair Loss	☐	☐	☐	☐	☐	☐	Other:						
Heart Disease	☐	☐	☐	☐	☐	☐	Other:						

Habits

☐ Alcohol: Type Amount per week:	☐ Diet: Good( ) Fair( ) Poor( ) Salt Intake: High( ) Low( ) Fat Intake: High( ) Low( )	☐ Sleep: Difficulty Falling Asleep Sometimes( ) Always( ) Insomnia: Yes( ) No( ) Daytime Somnolence: Yes / No	☐ Smoke: Packs Daily How many years: Interested in stopping? Yes / No
☐ Coffee: Cups per day Marijuana/ Other Drugs: Yes / No	☐ Exercise: Yes( ) No( ) Frequency: Daily( ) Weekly( )	Chronic Fatigue: Yes / No Other:	

Comments:

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent Z.Michael Taweh MD PC may use and disclose protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to Notice of to Z.Michael Taweh MD PC privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Z.Michael Taweh MD PC reserves the right to revise his Notice of Privacy Practices at anytime.

With my consent, Z.Michael Taweh MD PC and his staff may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Z.Michael Taweh MD PC and his staff, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder letters and patient statements as long as they are marked "Personal & Confidential." I have the right to request that Z.Michael Taweh MD PC restrict how he uses or discloses my PHI to carry out TPO.

By signing this form I am consenting to Z.Michael Taweh MD PC and his staff's use and disclosure of PHI to carry out TPO. If I do not sign this consent, Z.Michael Taweh MD PC may decline to provide treatment for me. I have been given the opportunity to review the Notice of Privacy Practices for the office of Z. Michael Taweh MD PC

___ with my consent, Z.Michael Taweh MD PC and his staff may disclose information regarding my medical care or medical condition to the following.

_____Relation:_____

_____Relation:_____

___I do not consent to release information regarding my medical care or medical condition to any family members including caregivers.

_____
Patient's name or legal guardian

_____ _____
Signature of patient or legal guardian Date

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name:	Phone Number:
Patient Street Address:	City, State and Zip Code
DOB:	Social Security Number:

I hereby authorize the office of : _____

Address: _____ **CITY** _____ **ST** _____

Phone_____ **FAX**_____

to make uses and disclosure of my protected health information (information pertaining to my medical records and/or financial records) as indicated below.

The information is to be disclosed to the office of

Z. Michael Taweh, M.D.27 Hospital Avenue, Suite 405 Danbury, CT 06810
Phone (203) 730-2900 Fax (203) 437-6929

Description of Information to be disclosed: latest Labs, EKG, diagnostic testing, last office note

For dates of treatment from _____ to _____.

Reason for requested use or disclosure:
□ Transfer of health coverage □ Personal use
□ Form completion □ Referral
□ Change in health care provider □ Other: (Please list reason below.)

This authorization expires in 6 months from the date signed or earlier _____ (state date).

To be read and signed by patient:

I understand the following:
a. I may revoke this authorization at any time by providing written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. The practice will not condition treatment or payment based on my signing this authorization.
d. I am signing this authorization freely and under no pressure from any individual to do so.
e. The information disclosed on this authorization may be subject to redisclosure by the practice and no longer protected by federal law.
f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.
g. I will receive a copy of this completed and signed authorization form.

Patient Signature:	Date of Signature:
Signature of Patient's Representative:	Relationship: Date: