



**PATIENT INFORMATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

**INSURANCE INFORMATION**

Responsible Party: \_\_\_\_\_

Relationship: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

ID Number: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

ID Number: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES(HIPPA)**

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Policy. I further acknowledge that a current copy of this document will be posted in the reception area, and that I may request a copy of any amendments at each appointment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**ASSIGNMENT AND RELEASE OF INSURANCE INFORMATION/SELF-REFERRAL**

I certify that I or my dependent have insurance with the above mentioned insurance company or companies and assign directly to David A. Schwindt, MD all insurance benefits for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I acknowledge that I am responsible to notify David A. Schwindt, MD of any changes in my insurance or address. I understand that I may be seeking specialty care without a referral, and that I am responsible for applicable copayments and deductibles or the total cost of the services I receive according to the terms of my coverage.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare Benefits be made on my behalf to David A. Schwindt, MD for any services provided. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine benefits or the benefits payable for related services. I understand that Medicare may deny payment for services if I have exceeded its published annual coverage limits for specific services, and that I am responsible for paying any balances in such instances.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**RELEASE OF MEDICAL RECORDS TO:**  
**David A. Schwindt, MD 23 Clara Drive Mystic, CT 06355 (860)572-0010**  
**Fax (860)536-2799**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

I, the undersigned, hereby request and give permission to:

\_\_\_\_\_  
(Name of Person or Agency releasing information)

\_\_\_\_\_  
(Address)

For the release of medical information from the treatment period of:

To:

David A. Schwindt, MD  
23 Clara Drive  
Mystic, CT 06355  
Phone: (860)572-0010  
Fax: (860)536-2799

This information is needed for the following purpose:

The specific information to be disclosed:

All Records       ER Records       Physical Therapy       EKG Reports

Lab Reports       X-Ray Reports       Other Radiology Reports

Operative Reports: \_\_\_\_\_

History & Physical       Discharge Summary

Other: \_\_\_\_\_

If my initials appear here \_\_\_\_, I specifically authorize release of drug/alcohol, &/or psychiatric records.

If my initials appear here \_\_\_\_, I specifically authorize release of HIV/AIDS information.

This information disclosed is CONFIDENTIAL and is protected by state and federal laws which prohibit any further disclosure of this information unless further disclosure is permitted by written consent of the person whom it pertains to or as otherwise permitted by the regulations as stated.

I understand this consent can be revoked by me at any time upon written request (not retroactively), and this authorization will expire 90 days from the date shown below unless revoked earlier.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness



PATIENT INTAKE FORM

Name: Phone: Work:  
Address: Email:  
Date of Birth: SSN:

How did you hear about our practice?

What Medical Problems have you been diagnosed with?

Any Previous Surgeries? Have you ever been hospitalized?  
(If yes, please list year of hospitalization and what condition warranted hospitalization  
&/or list year surgery was performed)

Allergies: Do you have any adverse reactions to medications? (Please List)

Medications: What medications do you currently take?  
(Please include prescriptions, over-the-counter, vitamins and herbal products)

| <u>Name</u> | <u>Dose</u> | <u>How Often</u> |
|-------------|-------------|------------------|
|-------------|-------------|------------------|

Do you use nutritional products/herbal medicine? If so, please elaborate, in detail, on back of this page....

Immunizations: Are your immunizations up to date? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Last Tetanus \_\_\_\_\_ Flu Shot \_\_\_\_\_ Pneumonia Shot \_\_\_\_\_

**PATIENT INTAKE FORM - PAGE 2 of 3**

Do you smoke tobacco:  
Have you quit (if so when)?

Cigarettes/day:

What is your alcohol consumption like (i.e., drinks per week)?

Any other drug use (this is a confidential form)?

What kind of work do you do?

With whom do you live?

Any pets or birds?

Any history of asbestos exposure (including working with brakes, rebuilding ships)?

(If yes, did you wear appropriate protection?)

What parts of the country have you lived in?

Have you gone on foreign travel for an extended time? If so, where?

**FAMILY HISTORY**

Still Alive?

Age

Health Problems

Mother

Father

Sibling(s)

Do these diseases run in your family(if so, please identify relationship):

Early Heart attack(males<55, Females<65)?

High Blood Pressure?

Diabetes?

Breast Cancer?

Colon Cancer?

Prostate Cancer?

Thyroid Disease?

Other Cancer?

Glaucoma?

Mental Health Issues?

**FEMALES ONLY:**

How old were you when you first started menstruating?

Are your cycles regular?

Date of first day of flow on last menstrual period?

Are you still menstruating?

How many days of flow?

Do you pass clots?

Any previous pregnancies?

Any miscarriages?

Elective Abortions?

Living Children(please list current age and child's gender)

**PATIENT INTAKE FORM – PAGE 3 of 3**

**REVIEW OF SYSTEMS**

Do you currently have any problems with (if yes, please describe):

- |   |                  |   |
|---|------------------|---|
| Night Sweats?                                     | Run Hot or Cold? | Headache?                               |
| Recent, unexplained weight loss?                  |                  | Sinus Headache?                         |
| Vision changes?                                   |                  | Migraines?                              |
| Dry eyes?   |                  | Runny Nose? Nasal congestion?           |
| Swollen Lymph Nodes?                              |                  | Nose Bleeds?                            |
| Dental Cavities?                                  |                  | Seasonal Allergies?                     |
| Mouth Ulcers?                                     |                  | Bleeding Gums?                          |
| Sore Throat? Hurts to swallow?                    |                  | Difficulty Swallowing?                  |
| Chest Pain/Pressure?                              |                  | Difficulty lying flat in bed?           |
| Palpitations (aware of heart racing in chest)?    |                  | Bilateral swelling in feet?             |
| Pain in legs with walking?                        |                  | One leg more swollen than other?        |
| Shortness of Breath (SOB)?                        |                  | Cough (&/or blood)?                     |
| SOB when exerting yourself?                       |                  | Wheezing?                               |
| Nausea/Vomiting?                                  |                  | Vomiting: Blood? Bile?                  |
| Loss of appetite?                                 |                  | Abdominal Pain?                         |
| Change in stools?                                 |                  | Yellow skin or eyes?                    |
| Painful urination?                                |                  | Sexually transmitted infections?        |
| Difficulty initiating urination?                  |                  | Kidney stones?                          |
| Getting up at night to urinate?(if so, how often) |                  | Pain when having sex?                   |
| Increased frequency of urination?                 |                  | Ability to obtain/maintain an erection? |
| Blood in urine?                                   |                  | Pain with ejaculation? Blood?           |
| Vaginal/Penile discharge?                         |                  | Nipple discharge?                       |
| Change in sexual desire(libido)?                  |                  | Breast changes?                         |
| Ability to reach sexual climax?                   |                  | Any problems sleeping?                  |
| Have you recently felt depressed?                 |                  | Ever attempted suicide?                 |
| Any previous psychiatric hospitalization?         |                  | New, one-sided weakness?                |
| Loss of sensation?                                |                  | Change in sensation?                    |
| Muscle aches?                                     |                  | New tremor?                             |
| Hip Pain?   |                  | Problems with balance?                  |
| Neck Pain?  |                  | Problems with memory?                   |
| Low Back Pain/sciatica?                           |                  | Easy bleeding?                          |
| Leg/arm/wrist/foot pain? Which joint?             |                  | Easy bruising?                          |
| Other joint pain?                                 |                  | Heavy Periods?                          |
|   |                  | Skin changes?                           |
| Other Rheumatic Problems?                         |                  |   |
| Other Complaints?                                 |                  |   |