EVAN SCHIFF, M.D.
HELENA GRABO, M.D.
36 East Main Street, Avon, CT 06001

NAME: LAST FIRST M.I.			SOCIAL SECURITY#: *(Last 4 digits required)*
STREET ADDRESS:			
CITY or TOWN: STATE: ZIP CODE:			HOME PHONE#: CELL PHONE#:
MAILING ADDRESS: *(If different)*			
EMPLOYER/OCCUPATION:	**PREFERRED PHONE#:**		WORK PHONE#:
DATE OF BIRTH:	SEX ASSIGNED AT BIRTH: M F	GENDER IDENTITY:	MARITAL STATUS: *(circle one)* Single Married Widowed Divorced
RESPONSIBLE PARTY INFORMATION: *(required if patient under age 18)* LAST NAME: FIRST NAME: M.I.			RELATIONSHIP TO PATIENT: CONTACT PHONE#:
RESPONSIBLE PARTY ADDRESS: STREET ADDRESS:			
CITY or TOWN: STATE: ZIP CODE:			
REFERRED TO THIS OFFICE BY:			DO YOU HAVE ADVANCED DIRECTIVES? *(A Living Will)* YES NO

EMERGENCY CONTACT:
NAME: **RELATIONSHIP TO PATIENT:** **DAYTIME PHONE NUMBER:**

ADDRESS*:* ***Permission to speak (circle one) Y N***

PAST MEDICAL HISTORY:	**MEDICATIONS: (Name, Dose, Frequency – including over the counter)**	**ALLERGIES: Please give Reaction**
PAST SURGICAL HISTORY:		
ANY CONCERNS FOR DOCTOR:		

FAMILY HISTORY: (Cancer, Diabetes, Heart Disease, etc.) _____ _____ _____ _____ **LAST COLONOSCOPY:**	**CHILDREN: Any medical problems:** _____ _____ _____ _____ **LAST MAMMO/PAP/BONE DENSITY**	**SOCIAL HISTORY:** **Smoking: YES NO** **Drugs: YES NO** **Alcohol: NONE RARE OCCASIONAL** **Amount per day:**

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER:		
SUBSCRIBER NAME:		
PATIENT'S RELATIONSHIP TO SUBSCRIBER: (CIRCLE ONE) Self Spouse Dependent Other:	POLICY ID#:	GROUP NAME/NUMBER:
SUBSCRIBER'S EMPLOYER AND EMPLOYER ADDRESS:	SUBSCRIBER SOCIAL SECURITY #: *(Last 4 digits required)*	SUBSCRIBER'S DATE OF BIRTH:
SECONDARY INSURANCE CARRIER:		
SUBSCRIBER NAME:		
PATIENT'S RELATIONSHIP TO SUBSCRIBER: (CIRCLE ONE) Self Spouse Dependent Other:	POLICY ID#:	GROUP NAME/NUMBER:
SUBSCRIBER'S EMPLOYER AND EMPLOYER ADDRESS:	SUBSCRIBER SOCIAL SECURITY #: *(Last 4 digits required)*	SUBSCRIBER'S DATE OF BIRTH:

I authorize Avon Medical Professionals, LLC to furnish information to insurance carriers concerning my illness and treatment, and I hereby assign to Avon Medical Professionals, LLC all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges whether or not such charges are reimbursed by insurance.

A copy of Privacy Practices of Avon Medical Professionals, LLC has been made available to me.

Your protected health information will be used by Avon Medical Professionals, LLC or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of this practice. You should review the NOTICE OF PRIVACY PRACTICES for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. Avon Medical Professionals, LLC reserves the right to modify the privacy practices outlined in this notice.

SIGNATURE: I have reviewed this consent form and give my permission to Avon Medical Professionals, LLC to use and disclose my health information in accordance with it. I have received or reviewed a copy of the Notice of Privacy Practices for Avon Medical Professionals, LLC

_____

Name of Patient Date of Birth

_____

Signature Date

_____

Signature of Patient Representative Relationship of Representative to Patient