RALPH ROSENBERG, M.D.
EVAN SCHIFF, 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#:
MAILING ADDRESS: *(If different)*			
EMPLOYER OR RETIREMENT DATE:	**PREFERRED PHONE#:**	WORK PHONE#: CELL PHONE#:	
DATE OF BIRTH:	SEX: Select One	MARITAL STATUS: *(circle one)* Select One	
RESPONSIBLE PARTY INFORMATION: *(required if patient under age 18)* LAST NAME: FIRST NAME: M.I.		RELATIONSHIP TO PATIENT:	
RESPONSIBLE PARTY ADDRESS: STREET ADDRESS:			
CITY or TOWN:	STATE:	ZIP CODE:	
REFERRED TO THIS OFFICE BY:		DO YOU HAVE ADVANCED DIRECTIVES? *(A Living Will)* Select One	

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

ADDRESS:

MEDICAL HISTORY: LIST ANY MEDICATIONS YOU TAKE REGULARLY:	PAST OR CURRENT ILLNESSES:	ALLERGIES:

INSURANCE INFORMATION

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

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

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

I authorize Ralph Rosenberg, M.D. & Evan Schiff, M.D. to furnish information to insurance carriers concerning my illness and treatment, and I hereby assign to Ralph Rosenberg, M.D. & Evan Schiff, M.D. 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 Ralph Rosenberg, M.D. & Evan Schiff, M.D. has been made available to me.

Your protected health information will be used by Ralph Rosenberg, M.D. & Evan Schiff, M.D. 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. Ralph Rosenberg, M.D. & Evan Schiff, M.D. reserves the right to modify the privacy practices outlined in this notice.

SIGNATURE: I have reviewed this consent form and give my permission to Ralph Rosenberg, M.D. & Evan Schiff, M.D. 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 Ralph Rosenberg, M.D. & Evan Schiff, M.D.

_____

Name of Patient Date of Birth

_____

Signature Date

_____

Signature of Patient Representative Relationship of Representative to Patient