HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name: (Last, First, M.I.): ______________________________ Date of birth: ______________

☐ Male ☐ Female

Referring doctor: ______________________ Date of last physical exam: ________________

PERSONAL HEALTH HISTORY

Diabetes	☐ No ☐ Diet Controlled ☐ Insulin ☐ Oral Medication ☐ Diet, Oral Meds ☐ Diet, Oral meds and Insulin
HBP	☐ Yes ☐ No ☐ Unknown If yes, please list medications taken ______________________
Kidney Disease	☐ Yes, Dialysis ☐ Yes, No Dialysis ☐ No
High Cholesterol	No _______ Unknown _________ Yes, Treated with medication _______ Yes, Not treated with lipid
Cerebrovascular Disease (Embolism)	Yes _________ No ________ Unknown _________
History of Heart Disease	Yes _________ No ________ Unknown _________
Previous Stroke	Yes _________ No ________ Unknown _________
Chronic Lung Disease	Yes _________ No ________ Unknown _________
Previous Heart Attack	Yes _________ No ________ Unknown _________
Previous Stent	Yes _________ No ________
Cardiac Surgery	Yes _________ No ________ Unknown _________
<u>Family</u> History of Heart Disease	Yes _________ No _______ If yes, please explain ______________________
Social History:	**Tobacco** Yes ______ No_____ Former ______ **Alcohol** Yes ______ No_____ Socially ______

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Other past Medical History including Surgeries		
Year	Reason	Hospital

List your prescribed medications and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

Review of Systems

Please check all that apply

☐ Fever	☐ Difficulty Swallowing	☐ Neck Pain
☐ Weight Change	☐ Diarrhea	☐ Seizures
☐ Double Vision	☐ Constipation	☐ Tingling
☐ Visual Loss	☐ Excessive Urination	☐ Numbness
☐ Throat Pain	☐ Pain While Urinating	☐ Fainting
☐ Chest Pain	☐ Urinating at Night	☐ Headache
☐ Palpitations	☐ Blood in Urine	☐ Dizziness
☐ Awakening at Night Short of Breath	☐ Rash	☐ Easy Bleeding
☐ Difficulty Breathing	☐ Pruritis (itching)	☐ Swollen Glands In Neck
☐ Wheezing	☐ Edema	☐ Depression
☐ Cough	☐ Arthalgia (joint pain)	☐ Memory Concerns
☐ Coughing up Blood	☐ Leg Pain While Walking	☐ Falls
☐ Difficulty Breathing while Lying Down	☐ Muscle Pain	☐ Difficulty Sleeping

REGISTRATION FORM

Jeffrey P. Thompsen MD LLC

Today's Date:	PCP:

PATIENT INFORMATION

Name: ____ Social Security Number: ________ - _________ - _______

Address: ____

Telephone Number: ________________________ Cell Phone ______________________________

City: __________________________________ State: ________________ Zip: ____________________

Sex: ☐ Male ☐ Female Age: _______ Birth date: ____________ Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by ____

Business Address____ Business Phone Number __________________________

Whom may we thank for referring you? ____

In case of emergency who should be notified? ______________________________________ Telephone number: ____________________________

PRIMARY INSURANCE

Person responsible for insurance: ________________________________ Relation to patient: _______________________________

Address if different from patient: _________________________________ Policy holder's social security ________________________

Insured's Employer: ____

Name of Insurance ___________________________________ Subscriber ID# _____________________________ Group #___________________

SECONDARY INSURANCE

Person responsible for insurance: ________________________________ Relation to patient: _______________________________

Address if different from patient: _________________________________ Policy holder's social security ________________________

Insured's Employer: ____

Name of Insurance ___________________________________ Subscriber ID# _____________________________ Group #___________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance medical coverage with the insurance company listed above. I assign directly to **Dr. Jeffrey P Thompsen MD** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ______________________________ ____________________________

Responsible Party Signature Relationship Date

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Jeffrey P. Thompsen MD
15 Palomba Drive, Suite 2
Enfield, CT 06082

Patients Name: ____

Date of Birth: ____

Home telephone number: ______________________

Cell phone number: _____________________________

Work number: ___________________________________

Local Pharmacy Name and Town: _________________________________

Family Doctor Name: ______________________________________

Referring Doctor Name: ____

***For test results...**

Do you have voicemail or an answering machine? Yes _____ No ______

Is it okay to discuss your test results and/or condition with other family members?
Yes ____ No _____

Name _____________________________ **Relationship** __________________________

Please circle where we can leave you a detailed message.
Home, Cell, Work

Is there someone we can give the test results to if you are not available? Yes____ No ____

If yes, please provide the name of person: ______________________

We now have a patient portal where patients can access their charts, ask questions regarding appointments, prescription refills and more. Please provide your email so that we may send you the link to access this site.

EMAIL ADDRESS: ____

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Jeffrey P. Thompsen MD
Cardiovascular Services
15 Palomba Drive, Suite 2
Enfield, CT 06082

Office Policies

Cancellations: Our office requires a 24 hour notice for canceled appointments. Patients will be charged a **$25.00** fee for appointments cancelled without a 24 hour notice. Fees may be waived due to emergent situations. This will be at the Doctor's discretion.
Please initial ___________

No Shows: Our office will confirm your appointment one to two days prior to your office visit. If you cannot keep your appointment due to an emergency, please notify our office promptly. There will be a **$50.00** charge for all no show appointments. This charge must be paid in full before any future appointments can be made.
Please initial ____________

Changes: It is the patient's responsibility to notify our office of any changes with your name, address, telephone number or insurance information. **Patients are responsible for providing a copy of their insurance information at every visit**. If your insurance company denies your visit, you will be responsible for the unpaid balance.
Please initial ____________

*__Nuclear Stress Testing:__ Our office will confirm your appointment **48 hours prior** to your visit. Once this call has been made if you cannot keep your appointment due to an emergency, please notify our office promptly. If the Service answers please leave a message with them notifying us of the need to cancel. If you fail to cancel or show up to this appointment there will be a **$250.00** charge. This charge must be paid in full before any future appointments can be made.
Please initial ____________

*__Deductible/Coinsurance Health Plans:__ If your insurance plan requires a **deductible or coinsurance** you will be responsible to make payments towards those costs at **each** office visit. Prices range from $100.00 to $426.00 depending on the type of visit. You will be informed of this charge during your reminder call.
Please initial ____________

I have read all of the above office policies, and understand the office procedures as outlined above.

_______________________________ ________________
Patient signature **Date**

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Consent and Acknowledge Form

I consent to the use or disclosure of my protected health information by Dr. Jeffrey P. Thompsen to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by Dr. Jeffrey P. Thompsen may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how Dr. Thompsen will use and disclose my information can be found in Dr. Thompsen Notice of Privacy Practices. I understand that this consent is effective for as long as Dr. Thompsen maintains my protected health information.

By signing below, I understand and acknowledge the following:

I have read and understand this consent, and
I have received Dr. Thompsen's Notice of Privacy Practices currently in effect

____
Print Name of Individual or Personal Representative

____
Date

____
Signature of Individual or Personal Representative

If signed by individual's representative, please describe legal authority of the representative to act on behalf of the individual:

____

Unable to obtain written consent and acknowledgement because:

☐ Individual refused
☐ Emergency Treatment situation
☐ Individual not able to sign due to incompetence or other medical reason
☐ Other: ____

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