NORWICH ENDOCRINOLOGY
CONSTANTIN CARSELI MD, FACE
Mandatory Government Standardization for
Health Care Quality Improvement

Patient Name:_____ Date:_____

RACE:
☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Native Hawaiian or other Pacific Islander
☐ Black or African American ☐ Hispanic ☐ Other Race ☐ Other Pacific Islander ☐ Unreported/Refused to Report

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to report

LANGUAGE: ☐ English ☐ Other ☐ Indian (Includes Hindi & Tamil) ☐ Spanish ☐ Russian

_____

Do you want to be added to the patient portal? ☐ Yes ☐ No

EMAIL: _____
(To be added to the patient portal you must. list your email address.)

The patient portal is a way for you to-communicate with our practice securely and efficiently. You will get an email reminder a few days before your appointment, along with a phone call 2 business days before your appointment.
IN THE FUTURE you may be able to view your personal health records, lab results and statements, request appointments, and request a prescription refill.

NORWICH ENDOCRINOLOGY
CONSTANTIN CARSELI MD, FACE
119 Sachem St. Norwich, CT 06360
Phone: (860) 859-3006 Fax: 860 859-1222
(Please Print)

Date: _____

Patient:_____ M___F___
Last Name First Name Middle Initial

Home Phone: ( ) _____Cell Phone: ( ) _____

Work Phone: ( ) _____You may contact me at my work number: Yes___ No___

To confirm my appointments, I would like to be called on my: Cell ____ Home ____

Patients Social Security#:_____ Date of birth: _____

Permanent Address:_____

City:_____ State:_____Zip Code:_____

Single___ Married___ Widowed___ Separated___ Divorced___

Primary Care Provider:_____Referring Provider: _____

Employer: _____Occupation: _____

Business Address: _____

Emergency Contact:_____Relationship:_____

Phone: ( ) _____

Your Drug Store:_____City:_____

Insurance:

Primary:_____ Secondary: _____

Policyholder Name:_____ Policyholder Name:_____

Policyholder Date of Birth:_____ Policyholder Date of Birth:_____

Subscriber/ID#:_____ Subscriber/ID#:_____

Group#:_____ Group#:_____

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MEDICATIONS / ALLERGIES

Today's Date: _____

Name:_____Date of Birth: _____

Allergies: _____

_____

_____

What medication should, be included?
(If you have a medication list, we will be happy to copy it for you and place it in your chart.)
Prescription medicines
Over-The-Counter medicines
Vitamins.*Herbal remedies *Nutrition pills
Respiratory therapy medicines (such as inhalers)

MEDICATION	PILL/DOSE TIME OF DAY	REASON FOR TAKING

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MEDICAL CONSENT/HIPAA FORM

Patient Name_____**D.O.B.**_____

I authorize Norwich Endocrinology to discuss my medical care with the following people:

(such as: names of physicians, family members, friends, etc.)

_____

_____

_____

I understand that it is my responsibility-to notify the office of any updates/changes to this form.

Signature of Patient
(or Representative)_____Date _____

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RELEASE OF INFORMATION AND AUTHORIZATION OF BENEFITS

I authorize Norwich Endocrinology LLC to release medical information, or anything pertaining to-the examination, treatment, history and medical expenses including preexisting condition information to my insurance company(ies) and/or its acting intermediary or agent, or employer/compensation carrier(s), or its legal representative for the purpose of processing insurance claims This release may include reviewing and/or photocopying pertinent documents for the purpose of payment by my insurance
company.

I authorize release of medical information to physicians, or health practitioners to whom I may be referred. I authorize payment of medical insurance benefits to be made directly to Norwich Endocrinology LLC I permit a copy of this authorization to be used in place of the original.

OFFICE POLICIES

I understand that it is, my responsibility to ensure that Norwich Endocrinology LLC participates with my insurance and that I am responsible for checking with my insurance to see if an insurance referral is required in order for the visit to be covered by my insurance or if I need a referral to referred elsewhere (i.e. other providers, laboratories, testing).Norwich Endocrinology LLC requires a 24 hour advanced cancellation notice, failure to notify the office will result in a $25 fee. A fee of $25 will be charged for a no-show. A fee of $25 will be charged for all-returned checks. There will be a fee for forms to be filled out and/or records to be copied.

I understand that I will be responsible for any charges not covered by my insurance company.

I have the right to request a copy of the Notice of Privacy Practices. Norwich Endocrinology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained from Norwich Endocrinology, 118 New London Tpke, Norwich, CT 06360.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date