REGISTRATION INFORMATION

Date_____ Cell Phone_____

Home Phone_____

Patient Name: (Last)_____(First)_____ M.I._____

Street Address_____City_____State_____Zip_____

Sex: M / F Birthdate:_____ Circle one: single married divorced widowed

Patient's SSN:_____

Employer:_____ Employer Telephone:_____

INSURANCE *POLICY HOLDER* INFORMATION

Name: (Last)_____ First _____M.I._____

SSN:_____ Birthdate: _____

Insurance Co. Name _____ ID# _____

Group # _____ Employer _____

Do you have secondary insurance Yes or No (Circle One)

SECONDARY INSURANCE *POLICY HOLDER* INFORMATION

Name: (Last)_____ First _____M.I._____

SSN:_____ Birthdate: _____

Insurance Co. Name _____ ID# _____

Group # _____ Employer _____

In case of emergency, please notify _____

Telephone _____ Relationship _____

Patient Signature (unless a minor) _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Sudipta & Bindu Dey, MD

127 Pines Bridge Road

Beacon Falls, CT 06403

203-881-2757

Name of Patient_____

I hereby acknowledge that I received a copy of this medical practice's Note of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed_____ Date_____

Print Name_____Phone_____

If not signed by patient, please indicate your relationship to patient_____

I wish to allow the following person(s) to have access to my health information:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

I understand that physicians have the privilege, and may request a copy of anything necessary to my treatment with them.

Patient Signature(or representative indicated above)_____

Sudipta & Bindu Dey, M.D., Inc.
127 Pines Bridge Road
Beacon Falls, CT 06403
P: (203) 881-2757
F: (203) 881-2303

PLEASE NOTE:

Our office policy states that if you have a chronic diagnosis (**HYPERTENSION, HYPERLIPIDEMIA, ETC.**) that requires you to be on any maintenance medication, **you are required by insurance companies to have blood work and a corresponding follow up visit with your physician every 6 months**.

However, if you are a **DIABETIC and on maintenance medication, you may need to have blood work and be seen in the office by your physician every 3 months**.

Thank you in advance for your cooperation.

Patient Name_____ Date_____

Patient Signature_____

Sudipta Dey, M.D.
Bindu Dey, M.D.
127Pines Bridge Road
Beacon Falls, Connecticut 06403

Patient Name _____ Account Number _____

PLEASE READ CAREFULLY AND SIGN THE SECTION PRINTED BELOW

I/We hereby guarantee payment of all charges incurred for the account of the patient listed above. If I do not pay the entire balance due within 90 days of the monthly billing date, or arrange for a payment plan that is agreed upon by the billing manager I/we understand that my balance is subject to be turned over to a collections agency.

I/We realize that failure to keep the account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for the additional services.

In the case of payments made by checks, I understand that I am responsible for a penalty fee set by the office for checks returned for insufficient funds. (As of 2/1/07 the fee is $40). I understand that checks will not be accepted to cover the balance of the penalty. Furthermore, I understand that after 2 checks returned in this manner, I will no longer be allowed to make payments to the office by check.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT. I AM AUTHORIZED TO EXECUTE THIS FORM AND ACCEPT AND AGREE TO THE TERMS SPECIFIED.

_____ _____
Date Signature of Patient (Unless a minor)

_____ _____
Witness Signature of Responsible Person other than patient

_____
Relationship to Patient

SUDIPTA AND BINDU DEY MD, INC.
127 PINES BRIDGE ROAD
BEACON FALLS, CT 06403

PATIENT INFORMATION SHEET

NAME:_____ DOB:_____ DATE _____

ALLERGIES:_____

PREFERRED PHARMACY: _____

SOCIAL HISTORY:

Recreational Drug Use:	Never	Past	Current
Smoking:	Never	Past	Current - Packs/Day:_____
Alcohol :	Never	Past	Current - Drinks/Day:_____

List ALL MEDICATIONS you take, including over the counter (OTC) medications and vitamins. Include specific doeses and when taken, If you don't know, please call your pharmacist to confirm.

Medications	OTC and Vitamins
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD	High Cholesterol	Psoriasis
Alcoholism	Dementia	HIV	Sciatica
Allergies, Seasonal	Depression	Hepatitis	Seizures
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stoke
Anxiety	Diverticulitis	Kidney Stones	Sleep Apnea
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Kidney Disease	Thyorid Disorder
Arthritis	Eczema	Lupus	Ulcerative Colitis
Asthma	Emphysema	Liver Disease	
Bipolar	Gallstones	Macular Degeneration	
Bladder problems /incontinence	GERD(Acid Reflux)	Migraines	
Bleeding problems	Glaucoma	Nosebleeds	
Cancer:_____	Heart Disease	Neuropathy	
Carpal Tunnel	Heart Attack (MI)	Osteopenia/Osteoporosis	
Headaches	Hiatal Hernia	Parkinson's Disease	
Crohn's Disease	High Blood Pressure	Peripheral Vascular Disease	

Other medical problems not listed above:

_____

Last Menstrual Period:	Yes / No	Date:_____	Normal / Abnormal
Mammogram:	Yes / No	Date:_____	Normal / Abnormal
Dxa (Bone Density)	Yes / No	Date:_____	Normal / Abnormal
Colonoscopy:	Yes / No	Date:_____	Normal / Abnormal
Retina Eye Exam:	Yes/ No	Date:_____	Normal / Abnormal

PATIENT INFORMATION SHEET
Page 2

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

_____ _____

Have you fallen in the last 6 months? Yes / No

If yes, please explain:

_____

FAMILY HISTORY: (Mother, Father, Siblings, Please indicate M/F or S next to the diagnosis)

Alcoholism	Breast Cancer	High Blood Pressure	Skin Cancer
Anemia	COPD/ Emphysema	High Cholesterol	Stroke
Arthritis	Colon Cancer	Kidney Disease	Thyroid Cancer
Asthma	Dementia	Lymph Cancer	Thyroid Disorder
Bipolar	Depression	Migraines	
Blood Cancer	Diabetes 1 or 2	Osteoporosis	
Blood Clot/DVT	Heart Disease	Prostate Cancer	

Other: _____

Do you have an Advanced Directive (Living Will)? Yes / No

List other medical providers you see on a regular basis (Cardiologist, Mental Health Provider, Kidney Doctor, etc...)

_____

_____

Patient Signature:_____ Date: _____

Provider Reviewed:_____ Date: _____