SPRINGFIELD MEDICAL ASSOCIATES, INC.
ENFIELD MEDICAL ASSOCIATES

AUTHORIZATION TO RELEASE INFORMATION

The HIPAA (Health Insurance Portability and Accountability Act) Privacy Act does not allow for unauthorized disclosure to a patient's family members, friends, or advisors. If the patient would like their protected health information released to someone other than himself or herself they must complete the bottom half of this form. A patient cannot specify which information they would like released to this third party. By completing this form, all protected health information may be released to the third party upon request until this agreement is terminated in writing.

I, _____, give Springfield/Enfield Medical Associates, Inc.
(Print Name)

permission to discuss my healthcare information with

_____ _____
(PRINT NAME) (RELATIONSHIP TO PATIENT)

___ Appointments ___ Diagnosis ___Treatment plans ___Test Results ___Procedures

_____ _____
(PRINT NAME) (RELATIONSHIP TO PATIENT)

___ Appointments ___ Diagnosis ___Treatment plans ___Test Results ___Procedures

_____ _____
(PRINT NAME) (RELATIONSHIP TO PATIENT)

___ Appointments ___ Diagnosis ___Treatment plans ___Test Results ___Procedures

and **permission** to leave a message on my

___ Home telephone answering machine # _____

___ Work voice mail # _____

___ Cell phone # _____

Signature: _____

Date: _____

Print Full Name: _____ Date of Birth: _____

Witness: _____
(Sign and Print Full Name) This must be a physician or staff member of SMA/EMA

2150 Main Street
Springfield, MA 01104

701 Enfield Street
Enfield, CT 06082

Springfield Medical Associates, Inc.
Enfield Medical Associates

Date: _____ Email: _____

Physician: _____ Referring Physician: _____

Patient Name: _____ Date of Birth: _____
First M.I. Last

Address: _____ Home Telephone #: _____
Street

Mobile Telephone #: _____

_____
City State Zip Code

Marital Status: _____ Gender: Male _____ Female _____

Employer: _____ Work Telephone #: _____

Employer's Address: _____
Street City State Zip Code

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____

Employer's Address: _____
Street City State Zip Code

Person to **Call** in case of an emergency: _____ _____
First Last Telephone #

Address: _____
Street City State Zip Code

Pharmacy Information: Name of Pharmacy you use: _____

Address: _____
Street City State Zip Code

Insurance Information – Please bring all insurance cards with you.

I understand that I am responsible for payment of services rendered regardless of insurance status.

_____
Signature of Patient or Guardian

Authorization to Release Information:
For billing purposes, I hereby authorize the billing staff to release any information acquired in the course of my examination or treatment.

_____ _____
Signature Date

Patient Authorization:
I have received a copy of the privacy notice provided to me by Springfield Medical Associates, Inc./Enfield Medical Associates which includes information regarding their participation in PVIX and the exchange of PHI for purposes of treatment, payment and operations.
PVIX Consent: Yes or No

_____ _____
Signature Date

Springfield Medical Associates, Inc.
Enfield Medical Associates

Medical History Form

Date of visit: _____ Name: _____ Referring MD: _____ MD: _____

Past Medical History -Indicate with an "X" if you have a history of any of the following:

___ AIDS/HIV
___ Allergy
___ Anemia
___ Arthritis
___ Asthma
___ Blood clots
___ Bowel disease
___ Cancer (type)
___ High cholesterol
___ Circulation problems
___ Depression
___ Diabetes
___ Eye disease
___ Fibromyalgia
___ Gallbladder disease
___ GERD
___ Gout
___ Headaches
___ Heart disease (type)
___ Hepatitis
___ High blood pressure
___ Inflammatory bowel disease
___ Irritable bowel syndrome
___ Jaundice
___ Kidney disease (type)
___ Kidney stones
___ Liver disease
___ Lung disease (type)
___ Lupus
___ Mental illness
___ Migraines
___ Mononucleosis
___ Muscle disease
___ Osteoarthritis
___ Osteoporosis
___ Phlebitis
___ Pleurisy
___ Pneumonia
___ Psoriasis
___ Raynaud's disease
___ Rheumatic Fever
___ Rheumatoid arthritis
___ Scarlet Fever
___ Scleroderma
___ Seizures
___ Sexually transmitted disease (Herpes, Gonorrhea, Syphilis)
___ Stomach or duodenal ulcer
___ Thyroid disease (type)
___ Tuberculosis/Positive PPD
___ Ulcers
___ Vasculitis
___ Other: (Explain) _____
_____
# of Pregnancies: _____
# of Live Births: _____
# of Miscarriages: _____
# of Abortions: _____
Transfusions: (Dates) _____
_____
Bone density test: (List dates & results) _____
_____

Surgeries -List procedures and dates.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medication Allergies -List medication and the nature of the reaction.

_____

Current Medications -List the name of the drug, dose and frequency of use. (Include prescription and over the counter.)

	Drug	Dose	Frequency		Drug	Dose	Frequency
1.				7.			
2.				8.			
3.				9.			
4.				10.			
5.				11.			
6.				12.			

Social History

Have you ever smoked cigarettes or cigars? _____ # of packs/day _____ For how many years? _____ Quit when? _____

Have you ever consumed alcohol (Beer, wine, whiskey)? _____ #of drinks/day _____ # drinks/week _____ Quit when? _____

Have you ever used other drugs (marijuana, cocaine, heroin, other? _____ Quit when? _____

What is your daily use of coffee? _____ Tea? _____ Soda? _____

Marital Status: _____ Occupation: _____ Asbestos exposure? _____Yes _____No

Military experience: _____ Past year's travels: _____

Hobbies/Exercise habits: _____

Immunization History

Pneumovax _____ Date Hepatitis _____ Date Mumps _____ Date Rubella _____ Date

Flu Vaccine _____ Date Polio _____ Date Measles _____ Date Tetanus _____ Date

Family History -For each family member list age, living (L) or deceased (D), and any illness.

Father: Age:_____ (L) _____ (D) _____ Illness: _____

Mother: Age:_____ (L) _____ (D) _____ Illness: _____

Siblings: Indicate male (M) or female (F).

(M/F) ___ Age: ___ (L) __ (D) __ Illness: _____ (M/F) ___ Age: ___ (L) __ (D) __ Illness: _____

(M/F) ___ Age: ___ (L) __ (D) __ Illness: _____ (M/F) ___ Age: ___ (L) __ (D) __ Illness: _____

(M/F) ___ Age: ___ (L) __ (D) __ Illness: _____ (M/F) ___ Age: ___ (L) __ (D) __ Illness: _____

Children: Indicate male (M) or female (F).

(M/F) ___ Age: ___ (L) __ (D) __ Illness: _____ (M/F) ___ Age: ___ (L) __ (D) __ Illness: _____

(M/F) ___ Age: ___ (L) __ (D) __ Illness: _____ (M/F) ___ Age: ___ (L) __ (D) __ Illness: _____

(M/F) ___ Age: ___ (L) __ (D) __ Illness: _____ (M/F) ___ Age: ___ (L) __ (D) __ Illness: _____

Women's History

Date of last Pap smear & results: _____

Date of last Mammogram & results: _____

Review of Systems -Circle any current problems:

Constitutional: Fever, chills, weight loss, weight gain, fatigue, sweats

Eyes: Dry eyes, redness, light sensitivity, visual loss, double vision, wear glasses/contact lenses

Ear, Nose, Mouth, Throat: Dry mouth, mouth sores, cavities, hoarseness, nosebleeds, sinus problems, hearing loss, ringing in ears, sore throat

Cardiovascular: Chest pain, shortness of breath, leg swelling, color changes of extremities, heart murmur, unable to lay flat, change in exercise tolerance

Respiratory: Cough, shortness of breath, trouble breathing, wheezing, phlegm, chest pain

Gastrointestinal: Abdominal pain, nausea, vomiting, diarrhea, constipation, black stools, blood in stool, mucus in stool, difficulty swallowing, pain on swallowing, loss of appetite, heartburn, change in stool, incontinence of stool

Genitourinary: Burning on urination, frequency of urination, blood in urine, incontinence of urine, vaginal discharge, abnormal menstrual bleeding, penile discharge, sexual difficulty

Skin: Rash, rash with sun exposure, hair loss, hives, nail changes

Musculoskeletal: Joint pain (which joints?) _____,

joint swelling (which joints?) _____,

morning stiffness (duration?) _____, back pain, muscle pain, muscle weakness, stiffness, jaw pain

Endocrine: Heat intolerance, cold intolerance, increased thirst, growth abnormalities, change in sexual function

Hematological/Lymphatic: Easy bruising, abnormal bleeding, enlarged glands, phlebitis, slow healing

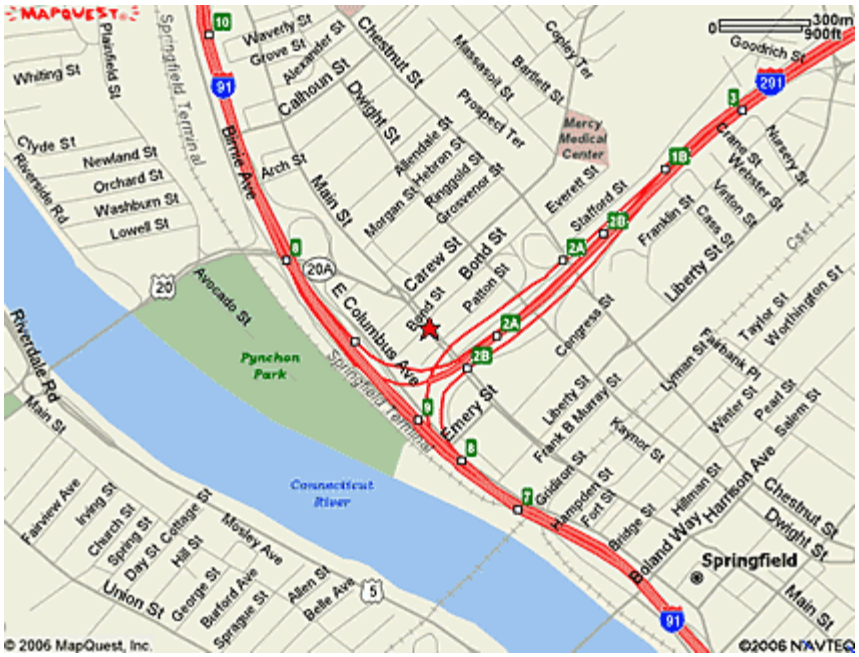
Psychiatric: Depression, stress, anxiety, trouble sleeping

Allergic/Immunologic: Allergic reactions

Neurological: Seizures, headaches, numbness, weakness, memory loss, dizziness, fainting, tingling, tremors

SPRINGFIELD MEDICAL ASSOCIATES

2150 Main Street
Springfield MA, 01104
(413) 739-5676



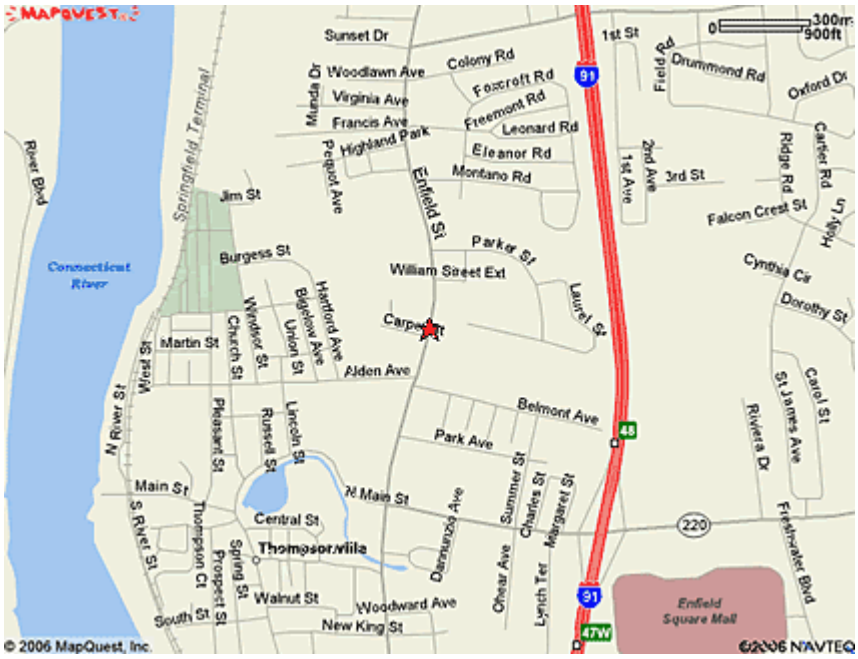
Directions: **From South**
Take I-91 North.
Take Exit 7 to 7A Main Street.
Continue through first set of lights.
Springfield Medical Associates is the third building on the right.

Directions: **From North**
Take I-91 South.
Take I-291 East.
Bear right onto Chestnut Street.
Take first right onto Congress Street.
At second intersection, turn right onto Main Street.
Proceed 0.2 miles. **Springfield Medical Associates** is the first building on the left, after the overpass.

(Please turn over for directions to the Enfield, CT office.)

ENFIELD MEDICAL ASSOCIATES

701 Enfield Street
Enfield, CT 06082
(860) 741-6058



Directions: **From North**
Take I-91 South
Take right onto Exit 49
Take a right onto Route 5 (Enfield St)
Proceed 1.4 Miles to **Mountain Laurel Professional Center** on left.

Directions: **From South**
Take I-91 North
Take right onto exit 48
Take left onto Route 220 (Elm St)
Take a right onto Route 5 (Enfield St)
Proceed 0.5 miles to **Mountain Laurel Professional Center** on right

(Please turn over for directions to the Springfield, MA office.)