DRS. BRENNAN, CRONIN, ALLEN, BERGHELLI & LICHTENFELS
2358 South County Trail
East Greenwich, RI 02818
401-886-6000

Today's Date: ________________ **Date of Birth:** __________________ **Age:** ______ **Sex:** **M** **F**

Last Name: ____________________________ First Name: _________________________ Middle: __________

Address: ____

City, State, Zip: ____

PHONE: Home/ ______________ Work/ ______________ Cell/ ____________ e-mail ______________________

Marital Status: S M D W Race____________ Language__________ Ethnicity: Hispanic/Latino **yes** or **no**

Hearing or Vision Barrier?_______________ Local Pharmacy name and Address #: __________________________

Occupation: __________________ Employer: _______________________

Emergency Contact:____________________________/ Relationship:____________________________

Phone: Home/ ____________________ Work/ ______________________

Responsible Party (**if minor**): __________________________ Relationship: ______________________________

Phone: Home/ __________________ Work/ ______________ Address: ______________________________

Who referred you to this office?____

Would you like access to our Patient Information Portal?___________________

INSURANCE Company Name: ______________________ Policy Number: ______________ **CO-PAY** ______

In whose name: _____________________ Relationship to patient: Spouse / Parent / Other: ______________________

DOB OF INSURED: __________________Employer: __________________ Phone #:_____________

SECONDARY INSURANCE: ____________________________ Policy Number _______________

Subscriber's name:_____________________DOB:_________Relationship:_______________

I request that payment of authorized insurance benefits be made on my behalf to Dr. Brennan, Cronin, Allen, Berghelli, and/or Lichtenfels for any services furnished me by this physician. I understand that my signature requests payment be made and authorizes release of medical information necessary to pay the claim. **I also understand that I am financially responsible f[illegible] balances not covered by my insurance carrier. A copy of this signature is valid as original.**

Signature:______________________________ **Date:**______________________________

MEDICARE WAIVER

I hereby take financial responsibility for any and all services not covered by Medicare Insurance.

Signature________________________________ **Date**__________________

DRS. BRENNAN, CRONIN, ALLEN, BERGHELLI & LICHTENFELS
PATIENT MEDICAL HISTORY

PLEASE FILL OUT THE FOLLOWING INFORMATION:

DATE:

PATIENT NAME:____DOB:____________________

MEDICAL HISTORY:____

____

SURGICAL HISTORY:____

____

ALLERGIES____

SOCIAL HISTORY:

SMOKING: YES/NO QTY/HOW OFTEN____________________QUIT DATE________

ALCOHOL YES/NO QTY/HOW OFTEN____________________QUIT DATE________

LAST COLONOSCOPY:________________WHERE:___________________________________

LAST MAMMOGRAM:_________________WHERE:___________________________________

PHARMACY & LOCATION:____

CURRENT MEDICATION LIST:

MEDICATION	DOSE	HOW OFTEN	PRESCRIBER

FAMILY MEDICAL HISTORY:

MOTHER____ALIVE/DECEASED

FATHER____ALIVE/DECEASED

SISTERS____

BROTHERS______________________________

Acknowledgement Of Receipt Of Our Notice Of Privacy Practices

From

Drs. Brennan, Cronin, Allen, Berghelli & Lichtenfels

We are required to make a ***good faith effort*** to obtain a patients written acknowledgement of receipt of our notice of privacy practices. The purpose of this acknowledgement process is to alert patients to the importance of our privacy notice and provide them the opportunity to discuss privacy issues with us.

Please sign below acknowledging that you have had the opportunity to read and/or obtain a copy of our privacy practices.

Please list any person or persons who you authorize us to give medical information to other then yourself.

Person's Name:	Relationship:
____________________	____________________
____________________	____________________
____________________	____________________

____________________	____________________
Patient Signature	Date

EMERGENCY CONTACTS

NAME	RELATIONSHIP	PHONE NUMBER

Drs. Brennan, Cronin, Allen, Berghelli & Lichtenfels
2358 SOUTH COUNTY TRAIL
E. GREENWICH, RI 02818
401-886-6000
FAX: 401-886-6002

Consent For Release of Confidential Health Care Information

Patient's name and address:

______________________________ DOB:_________
____
____
____

I hereby authorize:

____
____
____
____

Release Information to:

- Herbert J. Brennan, DO
- Charles L. Cronin III, DO
- Ryan S. Allen, DO
- Anthony V. Berghelli, DO
- Benjamin P. Lichtenfels, DO

Mail to:

2358 South County Trail
E. Greenwich, RI 02818

Reason for Transfer:

Transfer/continuity of care

I understand that my records are protected and under Federal Confidentiality Regulations and under the General Laws of RI and cannot be disclosed without my written consent except as otherwise specified by law.
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Any information released as a result of this consent shall not be further relayed in any way to any other person, organization, entity or other without an additional written consent from me.

I may withdraw this consent by giving written notification to the above party, at any time prior to the disclosure or release of the information. In the absence of my prior withdrawal, this consent will expire in:
__________3 months __________6 months__________1 year from this date

Signature of patient/Authorized Representative__________________________Date:___________
Relationship (if other then patient)

Patient Communication Form

We are in the process of implementing a new appointment reminder and patient communication system for our practice. Please help us make sure we have the most current contact information for your account.

By providing your contact information below, you are granting permission to be contacted via those communication channels. Your information will not be abused and will only be used to contact you regarding your care. Example communications include appointment reminders, reminders to schedule your next appointment and important announcements about our practice.

Name ______________________________ Home Phone ____________________

Address ______________________________ Cell Phone ____________________ ☐ Please do NOT text me.

______________________________ Email ______________________________

Please list any other minors or family members for which this same contact information applies.

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

I hereby grant my healthcare provider permission to contact me via an automated phone/text/email system. I authorize my healthcare provider to disclose to third parties who answer my phone or have access to my communications my limited protected health information, and to leave a message on these devices.

Signature ______________________________ Date ____________________

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