



**PAUL B. MURRAY, MD • MICHAEL ARON, MD**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_ Apartment #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Email Address: \_\_\_\_\_

Please tell us how you heard about our office? \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

**INSURANCE ASSIGNMENT:**

I request that payment of authorized Medicare Benefits/Commercial Insurance be made either to me or on my behalf to Paul B. Murray, MD LLC/Connecticut Hand and Orthopedics, PLLC for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that if my insurance plan requires a referral for the doctor's examination and one is not obtained, payment becomes my responsibility.

**ALL CHARGES ARE DUE AT THE TIME OF SERVICE. THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION IF SURGERY IS INDICATED. THE PATIENT IS RESPONSIBLE FOR THE COST OF COLLECTIONS/COURT FEES AND REASONABLE LEGAL FEES IN THE EVENT OF NON-PAYMENT FOR MEDICAL SERVICES.**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

{Paul B. Murray, M.D. LLC, 1000 Asylum Avenue – Suite 3220, Hartford, CT 06105}  
{Connecticut Hand and Orthopedics, PLLC, 1000 Asylum Avenue – Suite 3220, Hartford, CT 06105}

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

SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

If not signed by the patient, please indicate your relationship to the patient: \_\_\_\_\_



### MEDICAL INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ \*\* COVID Vaccinated:  YES  NO \*\*  
 Preferred Pharmacy: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Please place an "x" next to symptoms/medical conditions you have:**

<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> History of Blood Clot/DVT
<input type="checkbox"/> Anemia	<input type="checkbox"/> Numbness or Weakness	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Cancer, Tumor	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Ulcer, Stomach Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Drug Abuse/Alcoholism	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> History of MRSA/MSSA
<input type="checkbox"/> Fever or Chills	<input type="checkbox"/> Epilepsy, Seizures	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Other _____

Additional Medical History: \_\_\_\_\_  
 \_\_\_\_\_

Do you presently use or have you ever used any tobacco products? \_\_\_\_\_  
 \* If so, what type and how often/much? \_\_\_\_\_

List illnesses your blood relatives have had:

\_\_\_\_\_ Relative: \_\_\_\_\_  
 \_\_\_\_\_ Relative: \_\_\_\_\_  
 \_\_\_\_\_ Relative: \_\_\_\_\_

HOSPITALIZATIONS/SURGERIES:

\_\_\_\_\_ Approximate Date: \_\_\_\_\_  
 \_\_\_\_\_ Approximate Date: \_\_\_\_\_  
 \_\_\_\_\_ Approximate Date: \_\_\_\_\_  
 \_\_\_\_\_ Approximate Date: \_\_\_\_\_

MEDICATIONS:

DOSAGE & FREQUENCY:


ALLERGIES: \_\_\_\_\_  
 No Known Drug Allergies Do you have a Nickel allergy?  YES  NO



## CONSENT FORM FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

By signing this consent form, I understand that:

- I am giving my consent to PAUL B. MURRAY, MD LLC or CONNECTICUT HAND AND ORTHOPEDICS, PLLC (“the Practice”) for use and disclosure of the patient’s identifiable health information for the following purposes and activities:
  - **Treatment** (including, but not limited to, disclosures necessary for consultations with and/or referrals to other providers, the coordination of the provision of care and the scheduling of care.)
  - **Payment** (including, but not limited to, disclosures necessary for obtaining payment for the provision of care, determining eligibility for coverage, billing and utilization review.)
  - **Health Care Operations** (including, but not limited to, disclosures necessary for conducting quality assessment and improvement programs, care coordination, evaluating provider performance, conducting provider training programs, all of which might be conducted by the Practice or by organizations that license, accredit, monitor or contract with the Practice as a network provider, business management and administrative activities of the Practice.)
  - **Completion of Disability or Family Medical Forms** (as requested by the patient.)
- The information disclosed may include information relating to the patient’s:
  - Human immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS)
  - Treatment for or history of drug or alcohol abuse
  - Mental or behavioral health or psychiatric care
- This consent will remain valid until it is revoked by me or by my duly authorized representative.

Signature of patient or patient’s representative: \_\_\_\_\_

Printed name of patient or patient’s representative: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Date: \_\_\_\_\_