**Name:** _____**Date of Birth:** _____ **Date:** _____
**Marital Status:** ☐ S ☐ M ☐ D ☐ W Sex: ☐ M ☐ F
**Children:** ☐ Y ☐ N **How many**: _____ **Ages:** _____
**Occupation:** _____ **Employer:** _____ **Military:** ☐ Y ☐ N
**Handedness:** ☐ Right ☐ Left

---

**Social History:**

- Cigarette Smoking or Tobacco Use: ☐ Y ☐ N How many packs/day: ☐ <1 pack/day ☐ 1 or >1pack/day
  - Number of Years of Smoking: _____
  - Vaping: ☐ Y ☐ N
- Alcohol Use: ☐ Y ☐ N How often: ☐ Daily ☐ Weekends ☐ Socially ☐ Rarely
- Recreational Substances: ☐ Marijuana ☐ Cocaine ☐ Other _____
- Exercise Regularly: ☐ Y ☐ N ☐ 3-4 times/week ☐ daily ☐ Weekly
- Special Diet: _____ ☐ Low Fat/Low Cholesterol ☐ High Fiber ☐ Low Salt
- Hobbies: _____
- Education: ☐ High School ☐ College ☐ Graduate School ☐ Degree_____
- Living Arrangements: ☐ Own Home ☐ Rent ☐ Condo ☐ living with: _____
- Occupational Hazardous Exposure: ☐ Y ☐ N ☐ Blood/Body Fluids ☐ Toxins ☐ Other_____
- Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other

---

**Medication Allergies:** ☐ Y ☐ N
**Medication Nam**e: _____ **Reaction:** _____

**Current Medications:**
**(prescription & over the counter)**

☐
☐
☐
☐
☐
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☐
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☐
☐

---

**Have you ever been diagnosed with any medical conditions:** ☐ Y ☐ N

☐
☐
☐
☐
☐
☐

**Have you ever had any surgeries:** ☐ Y ☐ N

☐
☐
☐
☐
☐

**Family History:**

☐ Heart Disease
☐ Hypertension
☐ Diabetes
☐ High Cholesterol
☐ Thyroid Disorders
☐ Kidney Disease
☐ Cancers: _____
☐ Psychiatric Illness _____
☐ Other: _____

# EAST GRANBY FAMILY PRACTICE
# PATIENT INFORMATION SHEET
# ADDRESS UPDATE

***IMPORTANT:*** ***Please select and circle your Primary Care Physician***

***Dr. Ewald*** ***Dr. Howlett*** ***Dr. Ghumman***

***Dr. Freedman*** ***Dr. Reiher*** ***Dr. Lerner*** ***Dr. Pursnani***

**PATIENT INFORMATION**

Name _____

Address _____

Town _____

State _____ Zip _____

SSN ___ - ___ - _____

Employer _____

Language English Spanish French Other _____

**PHARMACY INFORMATION**

Name _____

Town _____

Pharmacy Phone/Fax # (  ) _____

**Please Circle:**

Sex: Female Male

Marital Status: Single Married Widowed Divorced Separated

Date of Birth ___ / ___ / ___

Patient Home (  ) _____

Patient/Parent Work (  ) _____

Patient/Parent Cell (  ) _____

**Please circle preferred number - Home Work Cell**

E-Mail _____

Emergency Contact _____

Contact Phone # (  ) _____

(preferably outside household)

**PATIENT RESPONSIBILITIES**

To assist our patients to understand their financial responsibilities to the practice and additional charges that may be applied to non-payment, missed appointment, cancelled appointments, etc., please note the following:

- I agree to pay **$50.00** fee for any appointment missed or if I fail to notify the office **24 hours** in advance.
- If I fail to pay my co-payment at time of my appointment, I agree to pay a **$10.00** billing charge.
- In divorce cases, remember that the adult seeking treatment is responsible for the bill regardless of their own personal problems. If the court has awarded custody of minor children to one person and financial responsibility to another, **the person bringing the child is responsible for payment of those services at the time of their visit.** A receipt can be provided should you wish to bill your estranged.
- I agree to pay **$25** fee for any check that is returned by my bank.
- If I fail to pay my bill in a satisfactory manner within 60 days and the account is assigned to a collection agency, I will pay the costs of a one time collection fee of **$25.00**. If required I will also be responsible for attorney's fees.
- I understand that the office can only bill for a diagnosis documented in my record, and that to ask the doctor to change a diagnosis to secure insurance payments constitutes fraud.
- We ask that each of our patients now take the responsibility of knowing what their specific health benefits are. Our office will continue to submit insurance claims as a courtesy to our patients. However, we regret that we can no longer commit to knowing what each insurance company will pay on any given procedure.

**AUTHORIZATION AND RELEASE:** I hereby authorize payment for any services on my behalf be made directly to the doctor. I understand that I am responsible to the doctor for charges not covered by my insurance company. I hereby authorize my physician to release any information required to support my claim, treatment, health care operations and for other purposes that are permitted or required by law.

_____ _____

Patient's Signature or Legal Guardian (Specify relationship to patient) Date

**Do you have an advanced directive/living will? (please circle)** **YES** **NO**

**If yes, please provide a copy to the doctor.**

# EAST GRANBY FAMILY PRACTICE
# PATIENT INFORMATION SHEET

***IMPORTANT: Please select and circle your Primary Care Physician***

***Dr. Ewald*** ***Dr. Howlett*** ***Dr. Ghumman***

***Dr. Freedman*** ***Dr. Reiher*** ***Dr. Lerner*** ***Dr. Pursnani***

**PATIENT INFORMATION**

Name _____

Address _____

Town _____

State _____ Zip _____

SSN ___ - ___ - _____

Employer _____

Language English Spanish French Other _____

**PHARMACY INFORMATION**

Name _____

Town _____

Pharmacy Phone/Fax # ( ) _____

**Please Circle:**

Sex: Female Male

Marital Status: Single Married Widowed Divorced Separated

Date of Birth ___ / ___ / _____

Patient Home ( ) _____

Patient/Parent Work ( ) _____

Patient/Parent Cell ( ) _____

**Please circle preferred number - Home Work Cell**

E-Mail _____

Emergency Contact _____

Contact Phone # ( ) _____

(preferably outside household)

**If this information is not completed IN FULL, your claim may be denied by your insurance company, and become your responsibility. We destroy the previous sheet, old information is not transferable. PLEASE COMPLETE!**

| **INSURANCE INFORMATION** | **PRIMARY** | **SECONDARY** |
|---|---|---|
| INSURANCE CO. | | |
| ID # | | |
| GROUP # | | |
| **SUBSCRIBER INFORMATION** | | |
| Subscriber Name | | |
| Subscriber SSN | - - | - - |
| Subscriber DOB | / / | / / |

**Subscriber is:** Self Spouse Parent Significant Other other (specify)

**PATIENT RESPONSIBILITIES**

To assist our patients to understand their financial responsibilities to the practice and additional charges that may be applied to non-payment, missed appointment, cancelled appointments, etc., please note the following:

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- If I fail to pay my co-payment at time of my appointment, I agree to pay a **$10.00** billing charge.
- In divorce cases, remember that the adult seeking treatment is responsible for the bill regardless of their own personal problems. If the court has awarded custody of minor children to one person and financial responsibility to another, **the person bringing the child is responsible for payment of those services at the time of their visit.** A receipt can be provided should you wish to bill your estranged.
- I agree to pay **$25** fee for any check that is returned by my bank.
- If I fail to pay my bill in a satisfactory manner within 60 days and the account is assigned to a collection agency, I will pay the costs of a one time collection fee of **$25.00**. If required I will also be responsible for attorney's fees.
- I understand that the office can only bill for a diagnosis documented in my record, and that to ask the doctor to change a diagnosis to secure insurance payments constitutes fraud.
- We ask that each of our patients now take the responsibility of knowing what their specific health benefits are. Our office will continue to submit insurance claims as a courtesy to our patients. However, we regret that we can no longer commit to knowing what each insurance company will pay on any given procedure.

**AUTHORIZATION AND RELEASE:** I hereby authorize payment for any services on my behalf be made directly to the doctor. I understand that I am responsible to the doctor for charges not covered by my insurance company. I hereby authorize my physician to release any information required to support my claim, treatment, health care operations and for other purposes that are permitted or required by law.

_____ _____

Patient's Signature or Legal Guardian (Specify relationship to patient) Date

**OVER ------->>** **OVER ------->>** **OVER ------->>** **OVER ------->>**

# Acknowledgement of Receipt of Notice of Privacy Practices

## East Granby Family Practice, L.L.C.

13 Church Road, P.O. Box 518
East Granby, CT 06026
Attention: HIPAA Compliance Team
(860) 653-4526

**Name of Patient:** _____ **D.O.B.** _____

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, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

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

_____

---

**Do you have an advanced directive/living will? (please circle)** **YES** **NO**
**If yes, please provide a copy to the doctor.**

---

# EAST GRANBY FAMILY PRACTICE, L.L.C.

## Credit Card on File Authorization

13 Church Road
P.O. BOX 518
East Granby, CT 06026

Billing Dept: (860) 653-0006
Fax: (860) 653-5209

**EDWARD M EWALD, M.D.**
**DAVID R. HOWLETT, M.D.**
**KHURAM GHUMMAN, M.D.**
**ELIZABETH S. FREEDMAN, M.D.**
**DANIEL LERNER, D.O.**
**NEENA PURSNANI, M.D.**
**MARYANN WEBSTER, A.P.R.N.**
**JEANNIE CRABTREE, A.P.R.N.**
**KATHERINE TAYLOR, A.P.R.N.**
**KERRI H. ANDERSON, A.P.R.N.**
**GRACE W. BROWN, A.P.R.N.**
**HAROLD WRIGHT, P.A.**
**MEGHAN KELLY, P.A.**

Please complete this form if you would like ***East Granby Family Practice, LLC*** to keep your credit, debit or HSA card on file for future payments.

Patient name: _____

Information to be completed by the card holder:

Cardholder Name: _____

Card Number: _____

Card Type: MasterCard / Visa / Discover / American Express

Expiration Date: _____ / _____

Security Code: _____

I,_____authorize ***East Granby Family Practice, LLC*** to charge the above card for payments owed for services rendered at their office. I agree to update any information regarding this account. The above information is complete and accurate to the best of my knowledge.

Amount authorized per month (please cirlce) — All copays and deductibles | Up to $100 / month | Up to $200 / month

Other Up to amount (please be specific):$_____. / month

If you select All copays and deductible, entire balance will be charged to your credit card, regardless of the total due.

If you select an up to amount, your card will be charged that amount each month.

Cardholder Signature _____. Date_____.

A receipt will be emailed or mailed to your home address on file with our office, unless you decide to opt out.

( ) Initial here to opt out.

A typical office visit for sickness or followup will be billed to the insurance company at a charge of between $85.00 and $200.00, with the allowed amount less than that, depending on your insurance company. This does not include any additional tests performed, such as bloodwork, urinalysis, EKG, xray, etc. Those are additional expenses and will be billed as additional charges.

**EAST GRANBY FAMILY PRACTICE, L.L.C.**
**13 CHURCH ROAD**
**P.O. BOX 518**
**EAST GRANBY, CT 06026**
**PHONE: (860) 653-4526**
**FAX: (860) 653-5209**

# 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 release 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 information may be released to the third party upon request until this agreement is terminated in writing.

I,_____, give East Granby Family Practice,

Permission to discuss with

_____ _____
(Print name) (Relationship to patient)

_____ _____
(Print name) (Relationship to patient)

_____ _____
(Print name) (Relationship to patient)

_____ _____
(Print name) (Relationship to patient)

Permission to leave message on

_____ Home telephone answering machine # _____

_____ Work voice mail # _____

_____ Mobile phone voice mail # _____

Any information pertaining to my healthcare.

Signature: _____

Print Full Name: _____

Date: _____

Witness: _____
(Sign and print full name) This must be physician or staff member of EGFP.

# EAST GRANBY FAMILY PRACTICE
# INSURANCE UPDATE SHEET

***IMPORTANT:*** ***Please select and circle your Primary Care Physician***

***Dr. Ewald*** ***Dr. Howlett*** ***Dr. Ghumman***

***Dr. Freedman*** ***Dr. Reiher*** ***Dr. Lerner*** ***Dr. Pursnani***

**PATIENT INFORMATION**

Name _____

Address _____

Town _____

State _____ Zip _____

SSN ___ - ___ - ____

Employer _____

Language English Spanish French Other _____

**PHARMACY INFORMATION**

Name _____

Town _____

Pharmacy Phone/Fax # ( ) _____

**Please Circle:**

Sex: Female Male

Marital Status: Single Married Widowed Divorced Separated

Date of Birth ___ / ___ / ____

Patient Home ( ) _____

Patient/Parent Work ( ) _____

Patient/Parent Cell ( ) _____

**Please circle preferred number - Home Work Cell**

E-Mail _____

Emergency Contact _____

Contact Phone # ( ) _____

(preferably outside household)

**If this information is not completed IN FULL, your claim may be denied by your insurance company, and become your responsibility. We destroy the previous sheet, old information is not transferable. PLEASE COMPLETE!**

| **INSURANCE INFORMATION** | **PRIMARY** | **SECONDARY** |
|---|---|---|
| INSURANCE CO. | | |
| ID # | | |
| GROUP # | | |
| **SUBSCRIBER INFORMATION** | | |
| Subscriber Name | | |
| Subscriber SSN | ___ - ___ - ____ | ___ - ___ - ____ |
| Subscriber DOB | ___ / ___ / ____ | ___ / ___ / ____ |
| **Subscriber is:** | Self Spouse Parent | Significant Other other (specify) |

**PATIENT RESPONSIBILITIES**

To assist our patients to understand their financial responsibilities to the practice and additional charges that may be applied to non-payment, missed appointment, cancelled appointments, etc., please note the following:

- I agree to pay **$50.00** fee for any appointment missed or if I fail to notify the office **24 hours** in advance.
- If I fail to pay my co-payment at time of my appointment, I agree to pay a **$10.00** billing charge.
- In divorce cases, remember that the adult seeking treatment is responsible for the bill regardless of their own personal problems. If the court has awarded custody of minor children to one person and financial responsibility to another, **the person bringing the child is responsible for payment of those services at the time of their visit.** A receipt can be provided should you wish to bill your estranged.
- I agree to pay **$25** fee for any check that is returned by my bank.
- If I fail to pay my bill in a satisfactory manner within 60 days and the account is assigned to a collection agency, I will pay the costs of a one time collection fee of **$25.00**. If required I will also be responsible for attorney's fees.
- I understand that the office can only bill for a diagnosis documented in my record, and that to ask the doctor to change a diagnosis to secure insurance payments constitutes fraud.
- We ask that each of our patients now take the responsibility of knowing what their specific health benefits are. Our office will continue to submit insurance claims as a courtesy to our patients. However, we regret that we can no longer commit to knowing what each insurance company will pay on any given procedure.

**AUTHORIZATION AND RELEASE:** I hereby authorize payment for any services on my behalf be made directly to the doctor. I understand that I am responsible to the doctor for charges not covered by my insurance company. I hereby authorize my physician to release any information required to support my claim, treatment, health care operations and for other purposes that are permitted or required by law.

_____ _____

Patient's Signature or Legal Guardian (Specify relationship to patient) Date

**Do you have an advanced directive/living will? (please circle)** **YES** **NO**

**If yes, please provide a copy to the doctor.**

# Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

**Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):**

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Dosage _____Method /Route_____ Time of Administration _____ Start Date ____/____/____ End Date ____/____/____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date _____/_____/_____

School Nurse Signature (if applicable) _____

**Parent/Guardian Authorization:**

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

## SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____
Signature Date

Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____

**Note: This form is a sample form in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)**

# Medication Administration Record (MAR)

**Name of Child/Student**_____ **Date of Birth** _____/_____/_____

**Pharmacy Name** _____ **Prescription Number** _____

**Medication Order**_____

| Date | Time | Dosage | Remarks | Was This Medication Self Administered? | Signature of Person Observing or Administering Medication |
|---|---|---|---|---|---|
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | | |

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete**

☐ **Medication is appropriately labeled**

☐ **Medication is in original container**

☐ **Date on label is current**

**Person Accepting Medication (print name)** _____ **Date** _____/_____/____

# Authorization For Use or Disclosure of Protected Health Information
# East Granby Family Practice, L.L.C.

13 Church Road
P.O. Box 518
East Granby, CT 06026
Attention: HIPAA Compliance Team
Phone: (860) 653-4526
Fax: (860) 653-5209

***As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, this practice may use or disclose your individually identifiable health information with your authorization except as provided in our Notice of Privacy Practices. You completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.***

I hereby authorize East Granby Family Practice to use and disclose health information concerning:

_____

(Patient name) Date of Birth

(Address) _____

**Description of health information to be used or disclosed** *(If this is an authorization for the use or disclosure of psychotherapy notes, it may not be combined with an authorization for the use and disclosure of any other type of health information except other psychotherapy notes)*:

_____
_____
_____
_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis and treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am authorizing such information to be disclosed to and used by:

Specify Name: _____

Address: _____
_____
_____

Phone: (_____)_____ Fax: (_____)_____

**The information will be used or disclosed for the following purpose(s) only:**

- ☐ Other insurance ☐ Legal process ☐ At the request of the individual or individual's representative
- ☐ Assist in the grievance/appeal process ☐ Assessment/referral/supervisory referral
- ☐ Other (specify):_____
_____

(Include one of the following, as appropriate:)

- ☐ I understand that my health care treatment or benefits will nor be affected whether I sign or do not sign this for ***or***

I understand that if I do not sign this form:

- ☐ I cannot participate in this research-related treatment.
- ☐ My health plan may enroll me or make me eligible for benefits.
- ☐ My physician will nor perform the expert, employment, life insurance or other physical or medical evaluation which would otherwise be performed solely for the purpose of disclosure to a third party.

**Effect of Refusal to Sign Authorization**

I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will nor affect actions taken by this medical practice prior to its receipt.

I understand that, if the recipient of the information is not a health care provider or health plan covered by the federal Privacy Rule, the information used or disclosed as described above may be redisclosed by the recipient and no longer protect by the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

This authorization is effective now and will remain in effect until _____
(expiration event or date).

I understand that I have the right to receive a copy of this authorization

Signed: _____ Dated: _____

Print name: _____

If not signed by the patient, please indicate relationship: _____

## How to Register

There are two ways to register for the Patient Portal.

### Option 1

Provide your email address so you can be given access to the Patient Portal. You will receive an email containing a link to register for the Patient Portal. Click on the link and follow the instructions. Enter the supplied Username and Password. You will be prompted to create a new Password. You will then have to enter information to verify your identity.

### Option 2

You can also be registered for the Patient Portal without providing your email address. We will print out a registration card with detailed instructions to follow. After accessing the website, enter the supplied Username and Password. You will be prompted to create a new Password. You will then have to enter information to verify your identity.

## East Granby Family Practice, LLC

13 Church Rd, PO Box 518
East Granby, CT 06026

(860) 653-4526

**Portal URL:**
egfpct.mymedaccess.com

Patient Portal powered by eMDs, Inc.

# Join Our Patient Portal

Access Your Health Information – Anytime, Anywhere!

# Patient Portal Frequently Asked Questions

Here are our answers to the most commonly asked questions about our Patient Portal.

### What is a Patient Portal?

A Patient Portal is a secure online website that gives you convenient 24-hour access to your personal health information and medical records—from anywhere with an Internet connection.

### Why Should I Use a Patient Portal?

Accessing your personal medical records through a Patient Portal can help you to be more actively involved in your own health care. Accessing your family members' health information can help you take care of them more easily.

Also, patient portals offer self-service options that can eliminate phone tag with your doctor and might even save a trip to the doctor's office.

### Is My Information Safe?

Yes. Patient portals have privacy and security safeguards in place to protect your health information.

Always remember to protect your Username and Password from others and make sure to only log on to the Patient Portal from a personal or secure computer.

### Can My Family Access My Patient Portal?

You may choose to give family members or healthcare proxies access to your Patient Portal. They will have their own login once you set this up in your Portal.

# What Do I Do If...

### I Don't Receive a Registration Email?

The emails may take a few minutes to deliver. You may also check your junk mail or spam folders to see if the email was routed there by mistake. If necessary, you can call the office to resend the registration e-mail.

### I Forgot My Password or Username?

Click on the link that says, "Forgot Password" or "Forgot Username" and follow the additional instructions. If you still need help, contact the office to reset your account.

### I Have An Urgent Issue or Emergency?

**DO NOT use the Patient Portal.** Call the office if you need to speak with a staff member immediately. If you are experiencing an emergency, call 911 or go to the nearest emergency room.

# Patient Portal Website

egfpct.mymedaccess.com

# Contact Us

East Granby Family Practice, LLC
13 Church Rd, PO Box 518
East Granby, CT 06026

(860) 653-4526

Visit us on the Web:
www.egfpct.com

# EAST GRANBY FAMILY PRACTICE, L.L.C.


**Edward M Ewald, MD**
**David R Howlett, MD**
**Khuram Ghumman, MD**
**Elizabeth S Freedman, MD**
**Anne M Reiher, MD**

**13 CHURCH ROAD**
**P.O. BOX 518**
**EAST GRANBY, CT 06026**
**PHONE: (860) 653-4526**
**FAX: (860) 653-5209**

**Daniel Lerner, DO**
**Neena Pursnani, MD**
**Maryann Webster, APRN**
**Jeannie Crabtree, APRN**
**Katherine Taylor, APRN**
**Krista Pochron, APRN**


## AUTHORIZATION TO OBTAIN & USE PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

**This document authorizes East Granby Family Practice, L.L.C. to obtain and use your Protected Health Information (PHI).**

**Name of individual(s) and/or practice(s) from which EGFP can receive your PHI from:**

**Doctor's Name:**_____**Phone#:(** **)** **-**_____

**Doctor's City, State:**_____**Fax#:(** **)** **-**_____

**Doctor's Name:**_____**Phone#:(** **)** **-**_____

**Doctor's City, State:**_____**Fax#:(** **)** **-**_____

**Information authorized to be obtained:**

- ⌗ All medical information concerning this patient for all dates of service.
- ⌗ Patient summary with most recent visit notes, physical, lab data, immunizations, problem list/past medical history.
- ⌗ Medical information of this patient compiled between ___/___/___ to ___/___/___
- ⌗ Other (specify):_____

Dates of Treatment, if known:_____

The information will be obtained, used, or disclosed for the **following purpose(s)** only:

- ⌗ Other insurance ⌗ Legal process ⌗ At the request of the individual or individual's representative
- ⌗ Assist in the grievance/appeal process ⌗ Assessment/referral/supervisory referral
- ⌗ Other (specify):_____

**I understand:**

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by sending written notice to the receiving and disclosing entities named above. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event:_____
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine eligibility for enrollment or benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

**I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.**

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____ _____

Description of Legal Representative Authority Expiration Date of Authorization

**NOTICE OF RIGHTS:** Information in you medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission, except in limited circumstances, including disclosure to persons who have had risk exposures, pursuant to an order of the court or the Department of Health, among health care providers for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified, unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

**Revised 03/18**

# State of Connecticut Department of Education
# Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

*Please print*

| Student Name (Last, First, Middle) | Birth Date | ❑ Male ❑ Female |
|---|---|---|
| Address (Street, Town and ZIP code) | | |
| Parent/Guardian Name (Last, First, Middle) | Home Phone | Cell Phone |
| School/Grade | Race/Ethnicity | ❑ Black, not of Hispanic origin |
| Primary Care Provider | ❑ American Indian/ Alaskan Native | ❑ White, not of Hispanic origin |
| | ❑ Hispanic/Latino | ❑ Asian/Pacific Islander |
| | | ❑ Other |
| Health Insurance Company/Number* or Medicaid/Number* | | |
| Does your child have health insurance? Y N<br>Does your child have dental insurance? Y N | If your child does not have health insurance, call **1-877-CT-HUSKY** | |

* If applicable

## Part I — To be completed by parent/guardian.
## Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Any health concerns | Y | N | Hospitalization or Emergency Room visit | Y | N | Concussion | Y | N |
| Allergies to food or bee stings | Y | N | Any broken bones or dislocations | Y | N | Fainting or blacking out | Y | N |
| Allergies to medication | Y | N | Any muscle or joint injuries | Y | N | Chest pain | Y | N |
| Any other allergies | Y | N | Any neck or back injuries | Y | N | Heart problems | Y | N |
| Any daily medications | Y | N | Problems running | Y | N | High blood pressure | Y | N |
| Any problems with vision | Y | N | "Mono" (past 1 year) | Y | N | Bleeding more than expected | Y | N |
| Uses contacts or glasses | Y | N | Has only 1 kidney or testicle | Y | N | Problems breathing or coughing | Y | N |
| Any problems hearing | Y | N | Excessive weight gain/loss | Y | N | Any smoking | Y | N |
| Any problems with speech | Y | N | Dental braces, caps, or bridges | Y | N | Asthma treatment (past 3 years) | Y | N |
| **Family History** | | | | | | Seizure treatment (past 2 years) | Y | N |
| Any relative ever have a sudden unexplained death (less than 50 years old) | | | | Y | N | Diabetes | Y | N |
| Any immediate family members have high cholesterol | | | | Y | N | ADHD/ADD | Y | N |

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date



**To be maintained in the student's Cumulative School Health Record**

# Part II — Medical Evaluation

## Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part I of this form

## Physical Exam

**Note:** *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

| | Normal | Describe Abnormal | Ortho | Normal | Describe Abnormal |
|---|---|---|---|---|---|
| Neurologic | | | Neck | | |
| HEENT | | | Shoulders | | |
| *Gross Dental | | | Arms/Hands | | |
| Lymphatic | | | Hips | | |
| Heart | | | Knees | | |
| Lungs | | | Feet/Ankles | | |
| Abdomen | | | | | |
| Genitalia/ hernia | | | | | |
| Skin | | | | | |

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

## Screenings

***Vision Screening**

| Type: | Right | Left |
|---|---|---|
| With glasses | 20/ | 20/ |
| Without glasses | 20/ | 20/ |

❑ Referral made

***Auditory Screening**

| Type: | Right | Left |
|---|---|---|
| | ❑ Pass ❑ Fail | ❑ Pass ❑ Fail |

❑ Referral made

| | Date |
|---|---|
| History of Lead level ≥ 5µg/dL ❑ No ❑ Yes | |
| ***HCT/HGB:** | |
| ***Speech** (school entry only) | |
| Other: | |

**TB:** High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

## *IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

**Asthma** ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

**Anaphylaxis** ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

**Allergies** *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

**Diabetes** ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

**Seizures** ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
*Explain:* _____
Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

**Student Name:** _____ **Birth Date:** _____ HAR-3 REV. 4/2017

# Immunization Record

## To the Health Care Provider: Please complete and initial below.

**Vaccine (Month/Day/Year)** Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

| | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 | Dose 6 |
|---|---|---|---|---|---|---|
| **DTP/DTaP** | * | * | * | * | | |
| **DT/Td** | | | | | | |
| **Tdap** | * | | | | Required 7th-12th grade | |
| **IPV/OPV** | * | * | * | | | |
| **MMR** | * | * | | | Required K-12th grade | |
| **Measles** | * | * | | | Required K-12th grade | |
| **Mumps** | * | * | | | Required K-12th grade | |
| **Rubella** | * | * | | | Required K-12th grade | |
| **HIB** | * | | | | PK and K (Students under age 5) | |
| **Hep A** | * | * | | | See below for specific grade requirement | |
| **Hep B** | * | * | * | | Required PK-12th grade | |
| **Varicella** | * | * | | | Required K-12th grade | |
| **PCV** | * | | | | PK and K (Students under age 5) | |
| **Meningococcal** | * | | | | Required 7th-12th grade | |
| **HPV** | | | | | | |
| **Flu** | * | | | | PK students 24-59 months old – given annually | |
| **Other** | | | | | | |

**Disease Hx of above** _____ (Specify) _____ (Date) _____ (Confirmed by)

**Exemption:** Religious _____ **Medical:** Permanent _____ Temporary _____ **Date:** _____

**Renew Date:** _____ _____ _____ _____

**Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.**
**Medical exemptions that are temporary in nature must be renewed annually.**

## Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

### KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

### GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

### HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

**Note:** The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number