Thank you for choosing Medical Associates of Cambridge for your medical care.

We look forward to meeting you. So that we can register all of your information into our electronic medical record, please arrive at your appointment **about 15 minutes before your scheduled time**.

Included with this letter is our *New Patient Questionnaire*. Please read through the questionnaire, complete all of the blanks and questions as best you can, and bring it with you to your upcoming visit. Your answers to the questions will help us make your first appointment as efficient as possible. **If you are unable to complete this questionnaire before your arrival, please come at the office about 30 minutes before your appointment** so that you can complete it then. Also, please remember to bring all of the following items to your first appointment:

- Completed New Patient Questionnaire
- Your current Insurance Card
- All of your current medications in their original containers, including any inhalers or over the counter medications you use on a regular basis

Thank you for your cooperation and we look forward to meeting you soon.

Sincerely,

Melody Gray
Practice Manager

New Patient Questionnaire (pediatric)

Please complete all of the following blanks.

_____ □ male
last first middle initial □ female

_____ - _____ - _____ _____
social security number date of birth

_____ _____ _____ _____
address (apt #) city state zip

_____ _____
home phone (□ preferred) mobile phone (□ preferred)

_____ _____ _____
person to notify in case of emergency phone # relationship

_____ _____ _____
mother's name phone # mother's date of birth

_____ _____ _____ _____
mother's address (apt #) city state zip

_____ _____
mother's employer employer phone

_____ _____ _____
father's name phone # father's date of birth

_____ _____ _____ _____
father's address (apt #) city state zip

_____ _____
father's employer employer phone

Our Financial Policy

•Our practice accepts insurance from most major insurance companies. As a courtesy to our patients, we will review your coverage and file your claim with your insurance carrier. We require you to assign all insurance company payments directly to our office.

•We will require you to bring and present your insurance card for every office visit or service.

•Payment is required at the time of service unless other arrangements have been made in advance. We accept cash, personal checks, MasterCard, and Visa. There is a $35 fee for any returned checks.

•Your insurance company requires us to collect any co-payments or payments toward your deductible at the time that service is provided.

•Prompt payment allows us to control costs. Overdue balances cost us both time and money. Each month, you will receive a statement of services rendered, payment of which is due within 30 days. If your payment is late and you have not previously made financial arrangements, then we will mail a reminder indicating that there is a problem with your account.

•We will require you to pay any overdue balance of 60 days or more before scheduling your next non-urgent office appointment. If payment is still refused at this point, we have the right to discharge you from the practice and turn your account over to a collection agency.

•If you are experiencing financial circumstances that prevent full payment at the time of service, please call to talk to our financial administrator who can help you set up a payment plan.

*** * ***

I have read and agree to abide by all of the above policies.

I request payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/other insurance company claim.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 on the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/other insurance company as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare/other insurance company.

Name of policy holder: _____

Signature: _____ **date:** _____

Notice of Privacy Practices

At Medical Associates of Cambridge, we are dedicated to strict patient confidentiality and protecting the privacy of your health information. No information about you is shared or distributed with any other persons or organizations without your signed authorization. Please read this policy and complete this form.

•I have received a copy of the Medical Associates of Cambridge Notice of Privacy Practices.
•I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information. I understand that this information may be used in the following manners:

-to obtain payment from third party payers
-to conduct, plan, and direct my medical treatment among multiple healthcare providers who may be directly or indirectly involved with my care
-to conduct normal healthcare services

•I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken regarding this consent.
•I understand that I may receive an expanded version of this Notice of Privacy Practices from this practice at any time.

Patient name: _____ Signature: _____ Date: _____

If representative of patient, name: _____ Relationship: _____

If you do not agree to sign this form, we are required to document your refusal. Reason for patient refusal to sign: _____

Office representative signature: _____ Date: _____

Protected Health Information

I authorize Medical Associates of Cambridge to use and disclose my Protected Health Information by the following methods:

•Home phone number: _____ **_____ Yes _____ No**

•Leave message on answering machine: **_____ Yes _____ No**

•Work phone number: _____ **_____ Yes _____ No**

•Cell phone number: _____ **_____ Yes _____ No**

•Fax or mail records to insurance company or other healthcare provider: **_____ Yes _____ No**

I authorize the following people to receive my protected health information:

_____ **relationship: _____ phone: _____**

_____ **relationship: _____ phone: _____**

_____ **relationship: _____ phone: _____**

•I consent to treatment necessary for the care of the above named patient.
•I authorize the release of all medical records to other healthcare providers involved in my care and to my insurance company, if applicable.
•I further authorize and request that insurance payments be made directly to Medical Associates of Cambridge, Inc. should they elect to receive such payment.

Patient name: _____ Signature: _____ Date: _____

If representative of patient, name: _____ Relationship: _____

Family History

Please answer all of the following questions so that we will understand your child's family's medical history.

•Was your child adopted? **Yes** **No**

•Tell us about your child's mother's health (check all that apply):

□ living □ deceased, if deceased, died at what age? _____
□ heart disease (angina, heart attack, needed stents or bypass)
□ congestive heart failure
□ diabetes □ high blood pressure □ high cholesterol □ COPD or emphysema
□ colon cancer □ breast cancer □ other cancer: _____
□ other: _____

•Tell us about your child's father's health (check all that apply):

□ living □ deceased, if deceased, died at what age? _____
□ heart disease (angina, heart attack, needed stents or bypass) □ congestive heart failure
□ diabetes □ high blood pressure □ high cholesterol □ COPD or emphysema
□ colon cancer □ prostate cancer □ other cancer: _____
□ other: _____

•Tell us about your child's sister(s)' health (check all that apply):

Number of sisters: _____

Sister 1

□ living □ deceased, if deceased, died at what age? _____
□ heart disease (angina, heart attack, needed stents or bypass) □ congestive heart failure
□ diabetes □ high blood pressure □ high cholesterol □ COPD or emphysema
□ colon cancer □ breast cancer □ other cancer: _____
□ other: _____

Sister 2

□ living □ deceased, if deceased, died at what age? _____
□ heart disease (angina, heart attack, needed stents or bypass) □ congestive heart failure
□ diabetes □ high blood pressure □ high cholesterol □ COPD or emphysema
□ colon cancer □ breast cancer □ other cancer: _____
□ other: _____

•Tell us about your child's brother(s)' health (check all that apply):

Number of brothers: _____

Brother 1

□ living □ deceased, if deceased, died at what age? _____
□ heart disease (angina, heart attack, needed stents or bypass) □ congestive heart failure
□ diabetes □ high blood pressure □ high cholesterol □ COPD or emphysema
□ colon cancer □ prostate cancer □ other cancer: _____
□ other: _____

Brother 2

□ living □ deceased, if deceased, died at what age? _____

□ heart disease (angina, heart attack, needed stents or bypass) □ congestive heart failure

□ diabetes □ high blood pressure □ high cholesterol □ COPD or emphysema

□ colon cancer □ prostate cancer □ other cancer: _____

□ other: _____

•Is there anything else the doctor should know about any of your child's other brothers' or sisters' medical history?

_____

_____

_____

_____

•Is there anything else the doctor should know about any of your child's family's medical history?

_____

_____

_____

_____

Personal History

Please answer all the following questions about your child's history.

1. Parent(s)' Occupation(s): _____

2. Parents: □ married □ live together □ divorced □ unmarried □ never together

3. Are there smokers that live in your child's home? (circle one) **Yes No**
   If Yes, do they smoke outside the home only? **Yes No**

4. Please describe your child's neighborhood: □ city □ suburban □ small town □ rural

5. Please describe your child's home: □ house □ apartment □ condo □ mobile home

6. Please describe the water source at your child's home: □ city water □ well/spring

7. Please describe the car safety that you use for your child:
   □ rear-facing car seat □ front-facing car seat □ booster seat □ seat belt □ none

8. Are there working smoke detectors in your child's home? **Yes No**

9. Are there guns kept in your child's home? **Yes No**
   If Yes, are the guns kept in locked storage? **Yes No**

10. Are there pets in you child's home? **Yes No**
    If Yes, what type of animals? _____

Please answer the following questions about your child's education.

1. List your child's current year/grade in school: _____

2. What grades in school does your child usually achieve?
   □ all As □ As and Bs □ Bs □ Bs and Cs □ Cs □ Cs and Ds □ Ds and Fs
   □ good □ satisfactory □ needs improvement

3. In school, my child is currently performing:
   □ below current grade level □ at current grade level □ above current grade level

4. Have you been told that your child has a learning disability? **Yes No**
   If Yes, specify what type of learning disability: _____

5. Does your child have any special needs? **Yes No**
   If Yes, specify what type of special needs: _____

6. Is your child currently enrolled in a gifted program? **Yes No**

The following questions are for adolescents between the ages of 10 - 16 years.

1. Do you know of any or suspect any abuse of tobacco by your child? **Yes** **No**
   If Yes: a. check which type used: □ cigarettes □ snuff/chewing tobacco
   b. how many packs per day? □ less than ½ pack □ ½ pack □ 1 pack □ 1 ½ packs
   □ 2 packs □ 2 ½ packs □ 3 packs □ other: _____

2. Do you know of any or suspect any abuse of alcohol by your child?
   If Yes: a. what kind of alcohol? □ beer □ wine □ mixed drinks □ liquor
   b. how often? □ 1-2 times/yr □ monthly □ weekly □ 2-3 times/week □ most days

3. Do you know of any or suspect any abuse of drugs by your child? **Yes** **No**
   If Yes: a. what kind of drugs? _____

4. Do you know or suspect that your child is involved in sexual activity? **Yes** **No**

Please answer all of the following questions.

1. Does your child have any history of psychiatric or emotional problem including depression or a suicide attempt? **Yes** **No**
   If yes, age of onset: _____ details: _____
   _____

2. Do you know of or suspect a problem with abuse with regards to your child?
   Physical **Yes** **No**
   Verbal **Yes** **No**
   Sexual **Yes** **No**

The following questions are about your child's mother.

1. Mother's age at time of child's birth: _____

2. Number of pregnancies: _____

3. Number of births: _____

4. Number of miscarriages: _____

5. Number of abortions: _____

6. Number of children currently living: _____

7. Types of previous deliveries:
   Number of elective c-sections: _____
   Number of emergency c-sections: _____
   Number of vaginal deliveries: _____

The following questions are about your child's birth.

1. Approximate weight at birth: _____

2. Approximate length at birth: _____

3. List any problems or illnesses your child had as a newborn: _____

_____

_____

_____