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 (adult)

Please complete all of the following blanks.

_____ □ male
last first middle initial □ female

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

□ married □ single □ separated □ divorced □ widowed

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

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

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

_____ _____ - _____ - _____ _____
spouse's name (if applicable) spouse's SS # (if insured) spouse's date of birth

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.

Health Insurance Company: _____

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: _____

Past Medical History

Please answer all the following questions so that we will understand your medical history.

•Do you have heart disease? **(circle for Yes or No)** **Y N**
If yes: a. check if you had: □ balloon angioplasty □ stents □ bypass surgery
details: _____
b. do you have congestive heart failure (CHF)? **Y N**
c. do you have a pacemaker or have a rhythm problem? **Y N**

•Do you have lung disease? **Y N**
If yes: a. COPD or emphysema? **Y N**
b. asthma? **Y N**
c. other lung disease: _____

•Do you have diabetes? **Y N**
If yes: a. treated with pills? **Y N**
b. treated with insulin? **Y N**

•Do you have high blood pressure? **Y N**

•Do you have high cholesterol? **Y N**

•Have you ever had a stroke or TIA ("ministroke")? **Y N**

•Do you have a thyroid conditions? **Y N**
If yes: a. underactive thyroid? **Y N**
b. overactive thyroid? **Y N**
details: _____

•Do you have a history of cancer? **Y N**
What kind?_____ What treatment ?_____

•Do you have a history of depression, anxiety, or bipolar disorder? **Y N**
details:_____

•Tell us about any surgeries you have had. **Check all that apply**:

□ heart bypass surgery	□ heart valve surgery	□ appendix removed
□ gall bladder removed	□ uterus removed	□ ovaries removed
□ prostate surgery	□ back surgery	□ hip replacement
□ knee replacement	□ lung surgery	□ colon surgery

Please provide details of all above surgeries and tell us about any other surgeries you've had:

_____

•Tell us about any hospitalizations you have ever had: _____
_____

•Is there anything else your doctor should know about your medical history? _____
_____

Family History

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

• Are you adopted? **Yes** **No**

• Tell us about your 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 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 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 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 your doctor should know about any of your other brothers' or sisters' medical history?_____
_____

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

Number of daughters: _____

Daughter 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: _____

Daughter 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 sons(s)' health (check all that apply):

Number of sons: _____

Son 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: _____

Son 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 your doctor should know about any of your family's medical history?

_____
_____
_____
_____

Personal History

Please answer all of the following questions.

•What is your marital status? □ married □ single □ separated □ divorced □ widowed

•Do you currently smoke cigarettes, cigars, pipe, or use any form of chewing tobacco? **Yes No**
If Yes: a. check which type you use: □ cigarettes □ cigars □ pipe □ chewing tobacco

•If you don't currently use any tobacco products, did you ever in the past? **Yes No**
If Yes: a. check which type you used: □ cigarettes □ cigars □ pipe □ chewing tobacco
b. in which year did you quit? _____

•If you smoke cigarettes now or ever did, about how many packs per day, on average, for most of those years?
□ less than ½ pack □ ½ pack □ 1 pack □ 1 ½ packs □ 2 packs □ 2 ½ packs □ 3 packs

•Estimate how many total years of your life that you have been or were using tobacco products:
□ less than 5yrs □ 5yrs □ 10yrs □ 15yrs □ 20yrs □ 25yrs □ 30yrs □ 40yrs □ 50yrs

•Do you currently drink alcoholic beverages? **Yes No**
If Yes, check all appropriate boxes: □ beer □ wine □ mixed drinks □ liquor

•If you don't currently drink alcoholic beverages, have you ever in the past? **Yes No**
If Yes, check all appropriate boxes: □ beer □ wine □ mixed drinks □ liquor

•If you drink alcoholic beverages now or ever did, estimate about how often:
□ 1-2 times/yr □ social gatherings only □ monthly □ weekly □ 2-3 times/week □ most days

•On the days that you do or ever did drink alcoholic beverages, about how many drinks would you have on average: □ 1 drink □ 1-2 drinks □ 2-3 drinks □ 4-5 □ 6-10 □ more than 10

•What is your current (or former, if retired) occupation(s)? _____

•Are your retired? **Yes No**

•Are you considered disabled or do you collect disability payments? **Yes No**
If Yes, for what condition are you considered disabled? _____

Review of Systems

Please answer these questions so that we will know all about your recent health issues.

General

- Do you seem to feel exhausted or fatigued most of the time? **Y N**
- Have you had a recent fever? **Y N**
- Have you gained or lost more than 10 pounds in the past 6 months? **(circle for Yes or No)** **Y N**

Head and Neck

- Do you have an earache? **Y N**
- Do you have trouble hearing? **Y N**
- Do you have problems with nasal drainage? **Y N**
- Do you have problems with nasal congestion? **Y N**
- Is your throat sore even when you don't have a cold? **Y N**
- Is your eyesight getting worse or blurry? **Y N**

Lungs

- Are you bothered by coughing? **Y N**
- Do you feel short of breath? **Y N**
- Do you sometimes have wheezing when you breathe? **Y N**

Heart and Blood Vessels

- Do you ever get pains or tightness in your chest? **Y N**
- Are you getting cramps or aching in your legs when you walk? **Y N**
- Do your legs often swell? **Y N**
- Have you been bothered by a racing heart or fluttering sensations in your chest? **Y N**

Digestion

- Do you have pains in your stomach? **Y N**
- Are your bowel movements ever bloody or have you had any bleeding from your rectum? **Y N**
- Are you constipated more than twice a month? **Y N**
- Are your bowel movements often loose for more than a day or two? **Y N**
- Are you troubled by heartburn? **Y N**
- Do you often become nauseated (sick to your stomach)? **Y N**
- Do you often have to vomit? **Y N**
- Is it difficult for you to swallow or do you feel like your food gets stuck? **Y N**

Urination

- Do you have burning or pain when you urinate? **Y N**
- Do you ever have blood in your urine? **Y N**
- Do you have to urinate more frequently than normal or get up at night frequently to urinate? **Y N**
- Do you sometimes feel you can't empty your bladder normally? **Y N**

Reproductive

For Men Only:

- Do you have trouble getting or keeping an erection or have other sexual problems that bother you? **Y N**
- Have you had any burning or discharge from your penis? **Y N**
- Are there any swelling or lumps on your testicles? **Y N**

For Women Only:

- Have you noticed any lumps in your breasts? **Y N**
- After you past your menopause, have you noticed any vaginal bleeding? **Y N**
- Have you had any bleeding between your periods? **Y N**
- Have you had any recent vaginal itch or discharge? **Y N**

Metabolism

- Do you have a tendency to feel too cold or hot? (circle one) **Y N**
- Have you been more thirsty than usual recently? **Y N**

Nervous System

- Do you often feel dizzy? **Y N**
- Does any part of your body often feel numb? **Y N**
- Is any part of your body often weak? **Y N**
- Do you have a tendency to worry a lot or feel nervous? **Y N**

Skin

- Do you have moles that are changing or growing? **Y N**
- Do you have a concerning rash? **Y N**
- Do you have sores that don't heal properly? **Y N**

Muscles and Joints

- Are you often troubled by back pain? **Y N**
- Are you troubled by painful muscles or joints? **Y N**
- Are you troubled by joints that swell? **Y N**

Blood and Immune System

- Do you have trouble stopping even a small cut from bleeding? **Y N**
- Do you have abnormal bruising? **Y N**
- Are there any swellings or lumps in your neck, armpits, or groin? **Y N**
- Have you had any recent allergic reactions to anything? **Y N**