Surgical Associates of Cocnord, P.C.
Andrea Resciniti, M.D.
131 ORNAC
John Cuming Building, Suite 435
Concord, Massachusetts 01742
-
Telephone (978) 371-7433

Welcome to the practice, we look forward to your upcoming appointment. Please read below to help facilitate your arrival and check in process. Enclosed is the new patient packet you need to complete and mail back to our office prior to your appointment on _____at _____.

- *Return completed forms as soon as possible* OR *arrive 20 minutes early to your appointment with the paperwork completed*

The *new patient packet* consists of:

1. Patient Information Sheet (*double sided*):
    a. Front Side: general and insurance information necessary for our office to accurately bill your insurance provider.
    b. Back Side: consent to disclose information, authorization to bill insurance company for services rendered, and a federal mandated statistical demographic reporting questionnaire.

2. Health History Form (*double sided*):
    a. Double-sided: general health questionnaire that we ask you to complete to the best of your ability. Be sure to include your medications and dosages, use another sheet of paper if necessary.

Patients enrolled with a managed care insurance (HMO) are responsible for obtaining a referral from their Primary Care Physician (PCP). Referrals cannot be initiated by a specialist. A written referral is processed by your PCP and sent to our office either electronically or via fax. A verbal referral does not fulfill the referral requirement set forth by your insurance carrier. Please be sure to notify your PCP with your appointment date to see Dr. Andrea Resciniti; all referrals are due prior to your scheduled appointment.

For patients with mammograms not performed at either Emerson Breast Center in Concord or the Westford Health Center, please ***hand carry*** your films and reports with you to your scheduled appointment. This rule applies for any other radiological and pathology testing not performed at Emerson Hospital or one of Emerson's satellite offices.

Effective August 1, 2009 the Federal Government is requiring us to check a photo ID on all patients due to the increase in insurance fraud. Please be sure to bring a PHOTO ID and your INSURANCE CARD with you to your appointment. ***Co-pays are expected at the time of your visit, we accept cash or check for payment.***

If you are unable to keep your scheduled appointment a 24 hour notice is appreciated. Thank you for your cooperation.

PATIENT INFORMATION SHEET

PRIMARY CARE PHYSICIAN:_____ REFERRED BY:_____

DATE OF LAST MAMMOGRAM:_____ REASON FOR APPOINTMENT:_____

NAME:_____ DOB: _____ AGE: _____ SEX:____

ADDRESS:_____ TOWN: _____ STATE: _____ ZIP:_____

HOME #:_____ CELL #:_____ MARTITAL STATUS:_____

If patient is a minor, parent/guardian name: _____ **Ok to leave a message confirming appointment?** Y N
(CIRCLE ONE)

EMAIL ADDRESS: _____@_____ **LATEX ALLERGY?** Y N

CURRENT MEDICATIONS WITH DOSAGES & VITAMINS (OR ATTACH LIST):

EMERGENCY CONTACT INFORMATION

NAME:_____ RELATIONSHIP:_____

PHONE #: _____ ADDRESS:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ ID#_____

SUBSCRIBER/POLICY HOLDER NAME:_____ SUBSCRIBER DOB:_____

SECONDARY INSURANCE:_____ ID#_____

SUBSCRIBER/POLICY HOLDER NAME:_____ SUBSCRIBER DOB:_____

EMPLOYER INFORMATION

EMPLOYER:_____ TELEPHONE:_____ Ok to leave a message? _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS/FRIEND

I hereby authorize my physician to release my medical information including tests & biopsies to the following:

NAME:_____ Relationship:_____

NAME:_____ Relationship:_____

NAME:_____ Relationship:_____

OVER

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION:

By my signature below, I herby authorize Surgical Associates of Concord, P.C. to disclose my medical information so that Surgical Associates of Concord, P.C. may treat me, seek payment from third parties for such treatment, and generally carry on the Surgical Associates of Concord, P.C. health care operations (e.g. quality assurance). I also authorize Surgical Associates of Concord, P.C. to disclose my medical information to insurers and providers outside of Surgical Associates of Concord, P.C. when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations.

MY HIGHLY CONFIDENTIAL INFORMATION:

I understand that my medical record currently contains or may contain in the future the following types of highly confidential information. By my signature below, I specifically consent to the disclosure of such information as part of my medical record to insurers and providers outside the Surgical Associates of Concord, P.C. for the purpose of obtaining treatment for me, payment for the treatment provided to me, and so that these entities can carry out their health care operations:

Information about genetic testing	Abortion consent
Information related to confidential communications with an allied health professional or human services professional	If I am an emancipated minor, information about my treatment and diagnosis (except my parents)
Information about venereal disease	Mammography records
Information about research involving controlled substances	Information about family planning services

STATISTICAL DEMOGRAPHICS:

In order to comply with federal reporting requirements, every healthcare provider is required to report to the Center's for Medicare and Medicaid Services each patient's race and ethnicity on an annual basis. The Center's for Medicare and Medicaid Services does not report individual data to the federal government but does report the total number of patient's within various categories.

I. **Ethnicity** ***(Choose only one.)***
- o Hispanic or Latino
- o Not Hispanic, Not Latino
- o Decline to answer

II. **Race** ***(Mark all that apply, however mark at least one.)***
- o *American Indian or Alaska Native* -- A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
- o *Asian* -- A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, e.g., Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- o *Black or African American* -- A person having origins in any of the black racial groups of Africa.
- o *Native Hawaiian or Other Pacific Islander* -- A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- o *White* -- A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- o *Decline to answer*

III. **Preferred Language:**_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize you to give me reasonable and proper medical care by today's standards. I hereby authorize physician to furnish to my insurance carrier concerning my medical care and treatments and hereby assign to the physician all my payments of medical service for myself and my dependents. I understand that I am responsible for any amount not covered by my insurance.
This is to certify I have read the above: Consent to Disclose My General Health Information, My Highly Confidential Information and Insurance Authorization and Assignment:

_____ _____
DATE SIGNATURE OF PATIENT

_____ _____
SIGNATURE OF PERSONAL RESPRESENTATIVE (if needed) DESCRIPTION OF AUTHORITY

HEALTH HISTORY

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pneumonia
- ☐ Pacemaker
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

AVERAGE BLOOD PRESSURE

HEIGHT WEIGHT

LOCAL PHARMACY INFO:

ALLERGIES To medications or substances

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates._____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date