Emerson Hospital
Walden Surgical Associates

First Name: _____**MI**: ____ **Last**: _____**I Prefer to be called**: _____

DOB: ___/___/_____ **SS#**: ___-___-_____ **AGE:** _____ **SEX:** M F **MARITAL STATUS**: S M W D SEP

Address: _____ **City/State:** _____**Zip Code:** _____

Please provide us with at least two phone numbers you can be reached at:

Home Phone: _____ **Cell:** _____ **Work:** _____

Which Phone is best to reach you? Home Cell Work **email address:** _____

May we contact you and/or leave a message? **Home?** Yes or No **On Cell** Yes or No **Work** Yes or no

May we discuss your condition with anyone? *(this does not include your PCP)* Yes or No **If yes, with whom?**

Name: _____**Relationship**: _____ **Name**: _____ **Relationship**: _____

Emergency Contact: _____**Relationship**: _____**Phone**: _____

Primary Care Physician: _____ **Address:** _____

CITY/State: _____**Phone:** _____ **Fax:** _____

Due to the federal meaningful use guidelines we are required by law to ask you the following questions. This information will become part of your medical record and will be kept confidential like all information in your record. We appreciate your cooperation as we strive to provide you with the best healthcare possible.

Preferred Language: _____ **EMPLOYMENT**: F PT RET STU N/A **Occupation**: _____

RACE: [ ] American Indian or Alaska Native [ ] Asian [ ] African American [ ] Caucasian [ ] Chinese [ ] Filipino [ ] Hispanic

[ ] Japanese [ ] Multiracial [ ] Native Hawaiian [ ] Pacific Islander [ ] Other [ ] Undetermined [ ] Declined to state

Ethnicity: [ ] Hispanic or Latino [ ] Non-Hispanic or Latino [ ] Other [ ] Undetermined [ ] Declined to state

Party responsible for payment: Self Spouse Parent/Guardian Other: _____

Name of Responsible party: _____ Phone: _____

This information is given for the purpose of establishing an account and medical file with Walden Surgical Associates. It is understood that I shall be responsible for any charges incurred by me (or any minor child as noted above). By signing below, I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize payment for any insurance claims be made directly to the physician.

By signing below, I understand *IF my insurance "requires a referral"* from my primary care physician, it is my responsibility to obtain one for all services rendered to Walden Surgical Associates. Failure to arrive to the office without a valid referral, may disrupt my scheduled appointment time and I will be asked to sign a waiver that acknowledges I am aware of financial responsibility should a referral be denied or not obtained.

Patient Signature: _____ **Date:** _____

Patient Representative (minor or unable to sign): Print: _____**Date:** _____

Patient Representative signature: _____**Relationship to patient:** _____

Form Updated 6/2020

Walden Surgical Associates Medical Health History Form

Name: _____DOB: _____/_____/_____ Age: ____ Gender: _____
Height: _____ Weight: _____ Referred By: _____ Primary Care: _____
Pharmacy: _____Address: _____

What is the Reason for your visit today? _____
Have you had any history of MRSA? [ ] NO [ ] YES: When: _____
HAVE YOU HAD AN ADVERSE REACTION TO IV CONTRAST: [ ] YES [ ] NO

ALLERGIES TO MEDICATION/FOOD/LATEX/ADHESIVES? [ ] YES [ ] NO **REACTIONS TO ANESTHESIA**?[ ] YES [ ] NO
Substance: _____Reaction: _____
Substance: _____Reaction: _____
Substance: _____Reaction: _____
Substance: _____Reaction: _____
Substance: _____Reaction: _____
Substance: _____Reaction: _____

PLEASE LIST CURRENT MEDICATIONS: ***Please include dosages and over the counter medication, vitamins or herbal supplements:*** *You can also provide us with a copy of a list from your PCP.*
1._____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

DO YOU ROUTINELY TAKE BLOOD THINNERS (Aspirin, Coumadin/Warfarin, Pradaxa) **AND/OR Anti-Inflammatories** (Aleve, Ibuprofen) [ ] NO [ ] YES If yes please list _____Last dose: _____
Do You have a history of a bleeding disorder? [ ] NO [ ] YES: _____

PAST/CURRENT MEDICAL HISTORY*: Please list current and prior medical history, even those controlled or corrected by medication (example high blood pressure, high cholesterol, asthma, heart attack, depression, diabetes etc. Please include approximate date of diagnosis)*
1._____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

PAST SURGICAL HISTORY: *Please list prior surgeries with approximate dates, no matter how long ago. (examples: appendectomy, gall bladder removal, tonsillectomy, hip or knee surgery etc.)*
OPERATION:
1._____ Year: _____ Reason: _____
2._____ Year: _____ Reason: _____
3._____ Year: _____ Reason: _____
4._____ Year: _____ Reason: _____
5._____ Year: _____ Reason: _____
6._____ Year: _____ Reason: _____

FAMILY HISTORY – Parents
Mother: [ ] Alive [ ] Deceased [ ] Unknown Father: [ ] Alive [ ] Deceased [ ] Unknown

Page 2 (continued) **Name: _____DOB: _____/_____/_____**

FAMILY HISTORY *(Continued) – Check all that pertained to immediate relatives and indicate their relationship to you.*

Is there any family history of The Following?

Colon Cancer: [ ] NO [ ] YES Relationship: _____Age Diagnosed _____
Breast Cancer: [ ] NO [ ] YES Relationship: _____ Age Diagnosed _____
Colitis: [ ] NO [ ] YES Relationship: _____Age Diagnosed _____
Osteoporosis: [ ] NO [ ] YES Relationship: _____Age Diagnosed _____
Heart Disease: [ ] NO [ ] YES Relationship: _____ Age Diagnosed _____
Glandular Conditions: [ ] NO [ ] YES Type _____Age Diagnosed _____
(adrenal, Pituitary, other)
Other Cancer: [ ] NO [ ] Yes Type _____Relationship _____Age Diagnosed _____

SOCIAL HISTORY:

Marital Status: _____ Number of Children: _____ Occupation: _____
Smoking: [ ] Never Smoked [ ] Smoked in the past: packs per day? ___ How many years? ____ When did you quit? _____
[ ] Currently smoking Packs/amount per Day? _____ Cigarette Cigars Vape/e-cigarette other
Do you drink alcohol? [ ] YES [ ] NO Alcohol intake: *Occasional socially* Amount: __ per day ___per week ___per month
Recreational Drug use? [ ] YES [ ] NO Exercise? YES NO If yes how often: _____
Living Situation: [ ] Live alone [ ] Live with spouse or significant other [ ] Live with a Child [ ] Live in a Facility or Group home

REVIEW OF SYSTEMS: Please check if ***you have or have had*** any of these **symptoms within the last month:**

CONSTITUTIONAL
[ ] Fever
[ ] Chills
[ ] Dizziness

EYES
[ ] Double Vision
[ ] Loss of Vision
[ ] Other: _____

EARS/NOSE/MOUTH/THROAT
[ ] Pain
[ ] Pressure
[ ] Deafness
[ ] Hoarseness

CARDIOVASCULAR
[ ] Chest Pain
[ ] Chest pressure
[ ] Irregular Heart Beat
[ ] Shortness of Breath
[ ] Palpitations

RESPIRATORY
[ ] Chronic cough
[ ] Shortness of breath
[ ] Sleep Apnea

GASTROINTESTINAL
[ ] Abdominal Pain
[ ] Vomiting
[ ] Heartburn
[ ] Change in Bowel Habits
[ ] Bloody Stools
[ ] Loss of Appetite

GENITOURINARY
[ ] Urinary Tract Infections
[ ] Kidney Stones
[ ] Waking up at night to urinate
[ ] Pain or Difficulty Urinating

MUSCULOSKELETAL
[ ] Joint Pain
[ ] Swelling
[ ] Weakness
[ ] Stiffness
[ ] Back Pain

NEUROLOGICAL
[ ] Weakness
[ ] Numbness
[ ] Speech Problems
[ ] Memory Problems
[ ] Headaches/Migraines

PSYCHIATRIC
[ ] Depression
[ ] Anxiety
[ ] Other _____

GYNECOLOGICAL HISTORY
Are you pregnant? [ ] NO [ ] YES
Last Menstrual Period: _____
Pregnancies: _____
Dates and types of delivery:
_____
_____
_____

Patient Signature: _____ Date: _____

Patient Representative (minor/or unable to sign) _____Date: _____

Relationship of patient representative to patient: _____
Provider Signature: _____Date: _____

Emerson Hospital

Walden Surgical Associates

PATIENT CONSENT FOR MASS HIWAY

The Massachusetts Health Information Highway (Mass HIway) is the secure statewide computer network that allows for the electronic transfer of medical information between health care providers that is intended to improve the quality and safety of patient care.

I have received and had an opportunity to review the "Mass HIway: Fact sheet for Patients" provided to me by a physician practice affiliated with Emerson Hospital and Emerson Physician Hospital Organization (the "Practice"). I hereby give the Practice permission to use Mass HIway to:

1.Send to the Mass HIway my name, date of birth, gender, email, home address, phone number and medical record number so that my other providers using Mass HIway know I received care from the Practice and can ask for my medical information when needed for my care.

2. Request, send, and receive my medical information from and to my other providers who also use the Mass HIway. I understand that this information may include information about mental health, HIV test results, sexually transmitted diseases, domestic violence, sexual assault substance abuse records, reproductive health concerns and genetic testing results.

3. I understand that I may withdraw my permission for the Practice to share information ("Opt-out") at any time by submitting a request in writing. The Opt-out notice can be sent to the Practice.

_____ _____

Print Patient Name | Patient Date of Birth

_____ _____

Signature of Patient or Patient's Legal Representative | Date of Signature

_____ _____

Print Name of Patient's Legal Representative (if applicable) | Relationship to Patient

The Mass HIway:
Fact Sheet for Patients

The Mass HIway is a secure statewide Health Information Exchange that allows your healthcare providers to safely and quickly send your health information to where it is most needed.

Doctors or nurses can care for you better when they have important information about your health. The Mass HIway is designed to make this safer and faster. The goal is better care coordination and quality for you and your family.

What is the Mass HIway?

- Mass HIway is the statewide health information exchange (HIE). Healthcare providers can use the Mass HIway to quickly and securely send and receive your health information to better coordinate your care.
- The Mass HIway is managed by the Commonwealth of Massachusetts' Executive Office of Health and Human Services (EOHHS).

How does the Mass HIway protect my information?

The Mass HIway has security measures in place to protect your information that aren't true of current methods, like fax, mail, or portable media like a CD or USB (flash drive), such as:

- Using a special code so that only authorized providers can read the information sent over the Mass HIway (this is known as encrypting data).
- Establishing policies and procedures that authorize the Mass HIway to suspend HIway participants as necessary to prevent unauthorized use of the Mass HIway.
- Overseeing who has access to the Mass HIway and who has used it for a patient's healthcare.

How can the Mass HIway help me?

- If you were discharged from a hospital, the Mass HIway can be used by the hospital to send your doctor a note about your hospital stay so that he or she is up to date about healthcare that you have received.
- If you get tests done, the doctor can use the Mass HIway to send the results to other members of your healthcare team, like your specialist. This helps them coordinate your care. It can also save time and money by reducing the need for repeat tests.
- If you have a chronic condition your health insurer case manager can use the Mass HIway to communicate with your doctors to coordinate your care and help you stay healthy.
- Not all of your healthcare providers may be using the Mass HIway yet. There may be more benefits to you as more healthcare organizations use the Mass HIway.

Who can use the Mass HIway and why?

- Currently the Mass HIway may only be used by healthcare organizations (like doctors' offices, hospitals, public health agencies, and health insurers).
- The Mass HIway can only be used for information sharing as allowed by federal and state privacy laws. You still need to give special permission for providers to request and receive certain sensitive information. You can speak to your healthcare provider about what information is sent over the Mass HIway.

Can I request my medical record from the Mass HIway?

- No. A patient's medical record itself is not part of the Mass HIway system. Talk to your provider for information about how to obtain your medical records.

Want more information?

- Talk with your doctor or their office staff about how they are using the Mass HIway.
- Visit www.masshiway.net, email us at masshiway@state.ma.us, or call us at 1-855-MA-HIway (624-4929) and press 3.

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Emerson Hospital

Patient Portal

Emerson Hospital is now offering an online secure messaging system. If you provide us with your email address, we can electronically send you information to register for the Patient Portal. Once you are logged into the system you are able to request records, test results, prescription refills, update your information and make appointments. Notifications will come to your personal email address and direct you back to the site. Many other Emerson providers are participating in this system and once you are registered you may find that you are able to contact other providers as well and you only need to register once.

If you are interested in signing up, please provide us with your email address below and you will receive registration directions in approximately 24 to 48 hours.

Name: _____ DOB: _____

Email:_____

This information will become part of your medical record and will be kept confidential, like all other information in your record.

Emerson Hospital

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Concord, MA 01742
Phone: 978-287-3547

Walden Surgical Associates is located in the ***John Cuming Building*** at Emerson Hospital. We recommend parking in either of the two open parking lot that run parallel to Route 2. There is ample handicap parking and when parking in the open lot, we will be validate your parking ticket for you. Valet parking is also available for your convience for $5.00. Please note we are unable to validate valet parking or parking in the main hospital garage, however, Valet is free for Handicap and patients needing assistance. Once you arrive in the John Cuming Building you will find the main elevators or stairs just before the laboratory. Our providers are in Suite 500.