Walden Surgical Associates

AK **Health History** **ER**

NAME:_____ **TODAY'S DATE**: _____

AGE: _____**BIRTHDATE**:_____ **HEIGHT**: _____ **WEIGHT**:_____

Referring Physician: _____ **Primary Care Physician**: _____

CHIEF COMPLANT (Reason for your visit today): _____

HAVE YOU EVER HAD MRSA: [ ] YES [ ] NO **PHARMACY** (name and location):_____

ALLERGIES: (please include: MEDICATIONS, LATEX, IV CONTRAST, SHELLFISH, and FOODS)

SUBSTANCE:	**REACTION**: (i.e.: rash, nausea, difficulty breathing)
_____	_____
_____	_____

MEDICATIONS: (THAT YOU ARE TAKING CURRENTLY) include all vitamins and supplements

NAME DOSAGE and FREQUENCY	NAME DOSAGE and FREQUENCY
_____	_____
_____	_____
_____	_____

Do you ROUTINELY take "blood Thinners" (Aspirin, Coumadin/Warfarin, Pradaxa) **and/or anti-inflammatories** (Aleve, Ibuprofen) [ ] YES [ ] NO IF **YES** PLEASE LIST: _____

Last Dose: _____ **Do you have a history of a bleeding disorder?** [ ] YES [ ] No

PAST/CURRENT MEDICAL PROBLEMS: (Please indicate the approximate date or your diagnosis)

PLEASE LIST: _____

_____

_____

_____

PREVIOUS SURGERIES: (DATE AND TYPE)

_____

_____

_____

_____

FAMILY HISTORY:

Parents: Mother [ ] Alive [ ] Deceased [ ] Unknown Father [ ] Alive [ ] Deceased [ ] Unknown

(Check any that pertain to immediate relatives and indicate their relationship to you as well as their age at his/her diagnosis)

Colon Cancer_____ Cancers _____

Colitis _____ Other Glandular problems (Adrenal, pituitary)

Osteoporosis _____ Heart Disease _____

Problems with Local Anesthesia _____

SOCIAL HISTORY:

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Alcohol use: (What type/amount/ how often)? _____

Tobacco Use: [ ] Never

[ ] Quit _____ Year Quit ? How Much (packs daily) _____ ? How Long _____

[ ] Current ? How Much (packs daily)_____ ? How Long _____

Occupation: _____

REVIEW OF SYSTEMS:

Have you commonly or recently had any of these symptoms? (Please circle any that apply).

Constitutional: Fever Chills Dizziness Night sweats

Eyes: Double 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

Psychiatric: Depression Anxiety Other:_____

Gynecological History: Are you currently pregnant?: [ ] YES [ ] NO Last Menstrual Period: _____

Pregnancies: Date(s) and type of Delivery: _____

_____

Patient Signature:_____ Date:_____

Physician Signature: _____ Date: _____

AK **Walden Surgical Associates** **ER**

Patient Registration Demographics

NAME: _____ **DATE OF BIRTH**: _____

SEX: [ ] Male [ ] Female **MARITAL STATUS**: [ ] single [ ] married [ ] divorced [ ] widowed

ADDRESS:_____

CITY: _____ **STATE**: _____ **ZIP CODE**:_____

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

(May We Contact You and/or Leave Messages) **At Home**: [ ] yes [ ] no **At Cell**: [ ] yes [ ] no **At Work**: [ ] yes [ ] no

PRIMARY CARE PHYSICIAN: _____ **REFERRING PHYSICIAN**:_____

***IF YOUR INSURANCE REQUIRES REFERRALS, YOUR ARE RESPONSIBLE FOR OBTAINING THEM PRIOR TO YOUR APPOINTMENT. YOU WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED FOR UNAUTHORIZED CARE.

PRIMARY INSURANCE COMPANY (IF CARD NOT COPIED) _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SUBSCRIBER'S NAME: (IF NOT THE PATIENT) _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____ SUBSCRIBER'S SOCIAL SECURITY #:_____

SECONDARY INSURANCE COMPANY (IF CARD NOT COPIED) _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SUBSCRIBER'S NAME: (IF NOT THE PATIENT) _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____ SUBSCRIBER'S SOCIAL SECURITY #:_____

JOB OR MOTOR VEHICLE ACCIDENT RELATED INJURY? [ ] YES [ ] NO DATE OF INJURY: _____

WORKERS COMPENSATION OR MVA POLICY CARRIER: _____

POLICY/CLAIM NUMBER: _____ ADJUSTER NAME & NUMBER: _____

PATIENT'S EMPLOYER: _____ PHONE NUMER: _____

WHOM MAY WE CONTACT IN THE EVENT OF AN EMERGENCY? _____

RELATIONSHIP TO THE PATIENT: _____ PHONE NUMBER: _____

MAY WE DISCUSS YOUR CONDITION WITH ANY MEMBER OF YOUR FAMILY? [ ] YES [ ] NO

IF YES, WITH WHOM? NAME: _____ RELATION TO PATIENT: _____

OTHER (S) _____

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 all charges incurred by me (OR any minor child as noted above). I authorize payment for any insurance claims be made directly to the physician.

I have received a copy of the Notices of Privacy Practices from WALDEN SURGICAL ASSOCIATES.

PATIENT SIGNATURE:_____ DATE:_____

PATIENT REPRESENTATIVE (minor/or unable to sign)_____DATE: _____

Relationship of the Patient Representative to Patient:_____

EMERSON HOSPITAL
AKNOWLEDGEMENT RECEIPT OF PRIVACY NOTICE
AND
CONSENT TO TREAT / DISCLOSE HEALTH INFORMATION

ACKNOWLEDGEMENT OF RECEIPT OF EMERSON'S NOTICE OF PRIVACY PRACTICES:
By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Emerson Hospital, the Emerson Hospital Health Centers in Westford and Groton, Emerson Hospital Radiology at Concord Hillside, Emerson Practice Associates, and any health care professional providing services in the Hospital's clinically integrated care setting, any members of our volunteer group that we allow to help you, and all employees, staff and other Emerson Hospital personnel (collectively, "Emerson").

CONSENT FOR TREATMENT / TO DISCLOSE MY GENERAL HEALTH INFORMATION:

By my signature below, I hereby authorize Emerson Hospital and those physicians, assistants and consultations as may be selected by them to render such care including diagnostic procedures, medical and surgical treatment and emergent blood transfusions, which may be necessary to care for me. I also authorize Emerson Hospital to disclose my medical information so that Emerson may treat me, seek payment from third parties for such treatment, and generally carry on Emerson's healthcare operations (e.g., quality assurance.) I also authorize Emerson to disclose my medical/ insurance information to insurers and providers outside of Emerson when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations. I also authorize Emerson to send me information regarding health services at Emerson Hospital.

ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY:

In consideration of services rendered, I hereby irrevocably assign and transfer to Emerson Hospital, it's physicians, assistants and consultants rights, title and interest in the benefits payable for services rendered related to this visit. If I am covered under Medicare, I hereby certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. Said irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance, but shall not be construed to be an obligation of Emerson Hospital to pursue any such right of recovery. Provided, however, this assignment and transfer shall not rake away from my standing to sue or make claim for benefits, individually, should coverage be denied by insurance carrier(s). I hereby authorize my insurance company(ies) to pay directly to Emerson Hospital, it's physicians, assistants and consultants for all charges incurred or alternatively, for all charges in excess of the sums actually paid pursuant to said policy(ies) that my providers are permitted to collect. A photo copy of this authorization shall be considered as effective and valid as the original.

_____ _____
Signature of Patient Date

If patient is a minor or Otherwise Incapacitated (physically or mentally) obtain the following Signatures

_____ _____ _____
Signature of Personal Representative Description of Authority Date

Emerson Hospital

Introducing 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.

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 healthcare providers that is intended to improve the quality and safety or 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 MassHiway 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 from 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 Patients Legal Representative (if applicable) Relationship to Patient