Watertown Medical Associates
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Patient Intake & Health Risk Assessment Form

GENERAL INFORMATION

Name: ________________________________ **DOB:** ________________ **Age:** _____

Street Address: _________________________ **City/Town:** _____________ **Zip:** ______

Race/Ethnicity:__________________________ **Gender:** ☐ Male ☐ Female ☐ Rather not say

Languages Spoken? ______________________ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Cell:______________ **Home:**______________ **Work:**______________ **Email:** _________________

Preferred Method of Contact: ________________ **Pharmacy:**____

Is it OK to leave detailed voice messages? ☐ Yes ☐ No **Is it OK to leave you detailed emails?** ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Insurance Co: ____________________ **ID#:**_____________________ **Group#:**________________

Primary Policy Holder:____________________ **DOB:** ____________________ **Relationship:**_____________

Secondary Insurance Co: ___________________ **ID#:**_____________________ **Group#:**________________

Secondary Policy Holder:___________________ **DOB:** ____________________ **Relationship:**_____________

Billing address (if different from above): ____

Where do you currently live? ☐ House, Apartment, Mobile Home ☐ Assisted Living Facility ☐ Nursing Home ☐ Other__________

Please Check Yes or No to the following:

Do you live alone? ☐ Yes ☐ No

Do you have a friend, relative or neighbor who can take care of you for a few days if necessary? ☐ Yes ☐ No

Do you have a Medical Power of Attorney (some to make medical decisions for you if you were unable?) ☐ Yes ☐ No

Do you have an Advanced Directive or a living will? ☐ Yes ☐ No

If yes, is a copy of it on file with our office? ☐ Yes ☐ No

HEALTH & WELLNESS

Current Height: Feet_______Inches_______ **Current Weight:** _______lbs

How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Are you currently experiencing any pain or discomfort? ☐ Yes ☐ No **If yes, where?**_____________ **For how long?**_______

Is it important for you to take an active role in your health care? ☐ Yes ☐ No

Do you feel confident that you know when to seek medical care and when to take care of yourself? ☐ Yes ☐ No

Do you feel comfortable talking to your doctor about health concerns, including intimate relations? ☐ Yes ☐ No

In the last 6 months, how many unplanned overnight stays as a patient have you had in a hospital? ☐ 0 ☐ 1 ☐ 2 ☐ 3 +

In the past 3 months, how often did you go to a walk in or emergency room? ☐ 0 ☐ 1 ☐ 2 ☐ 3 +

In the past 7 days, have you felt sleepy during the day? ☐ Yes ☐ No

How would you describe the condition of your mouth and teeth? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

When was the last time you had a:	In the last year	In the last 2-4 yrs	In the last 5 yrs	In the last 10 yrs	Never	Not Applicable	Doctor/Facility Name	Date of last appointment
Flu Vaccine?								
Pneumonia Vaccine?								
Shingles Vaccine?								
Mammogram?								
Colonoscopy?								
PAP Smear? ***(for women)***								
Bone Density Scan?								
Eye Exam?								
Hearing Exam?								
Dental Exam?								

Did you get a Covid-19 Vaccine?	If Yes, what Vaccine did you receive?	Date of first Vaccine
❏ Yes ❏ No ❏ Scheduled to receive it	❏ Pfizer ❏ Moderna ❏ Johnson & Johnson	_______/_____/______ **Date of Second Vaccine** _____ /______/_______

FOR DIABETES PATIENTS ONLY:

When was the last time you had a:	Date of last appointment	Doctor/Facility Name & Phone #
Eye Exam to detect diabetes-related issues for your **eyes** ?		

Podiatry Exam to detect diabetes-related issues for your **feet**?		

MEDICAL HISTORY

What Medical conditions DO YOU currently have, or have had in the past? Please Check all that apply:

- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Bi-Polar Disorder
- ☐ Cancer
  *Type*_______________
- ☐ COPD/Emphysema
- ☐ Coronary Heart Disease
- ☐ Dementia
- ☐ Heart Failure
- ☐ Memory Loss
- ☐ Diabetes
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Hypertension
- ☐ Osteoporosis
- ☐ Renal/Kidney Failure
- ☐ Stroke
- ☐ Schizophrenia
- ☐ ADD/ ADHD
- ☐ Covid-19

Other:____

FAMILY HISTORY

What medical conditions do you have in YOUR FAMILY history? Please Check all that apply:

- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Bi-Polar Disorder
- ☐ Cancer
  *Type*_______________
- ☐ COPD/Emphysema
- ☐ Coronary Heart Disease
- ☐ Dementia
- ☐ Heart Failure
- ☐ Memory Loss
- ☐ Diabetes
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Hypertension
- ☐ Osteoporosis
- ☐ Renal/Kidney Failure
- ☐ Stroke
- ☐ Schizophrenia
- ☐ ADD/ ADHD

Other:____

DAILY ACTIVITIES

Do you have difficulty doing the following? Please Check all that apply:

Standing from a sitting position?	☐ Yes	☐ No	Getting Dressed?	☐ Yes	☐ No
Walking in or out of the house?	☐ Yes	☐ No	Using the toilet?	☐ Yes	☐ No
Preparing and eating a meal?	☐ Yes	☐ No	Bathing?	☐ Yes	☐ No

Driving or getting places?	☐ Yes	☐ No
Organizing your day?	☐ Yes	☐ No
Writing or grasping small objects?	☐ Yes	☐ No

LIFESTYLE

How often do you eat healthy food (fresh fruits, fish & veggies?) ☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

How often do you eat unhealthy food (fried foods, sweets)? ☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Do you exercise regularly or take part in physical activity? ☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

How often do you use tobacco? ☐ Never ☐ 1-2 times a week ☐ 3-6 times a week ☐ Daily

☐ Former smoker, *approximate date quit*: ____________________

How often do you drink alcoholic beverages? ☐ Never ☐ 1-2 times a week ☐ 3-6 times a week ☐ Daily

How often do you use recreational drugs? ☐ Never ☐ 1-2 times a week ☐ 3-6 times a week ☐ Daily

Do you travel outside of the country? ☐ Never ☐ 1-2 time a year ☐ Monthly **Last Date traveled:**________
Where?__________________

Do you use a seat belt? ☐ Yes ☐ No

Do you own a firearm? ☐ Yes ☐ No

In the last 6 months, have you fallen down? ☐ Yes ☐ No

Have you had any problems in your household that have led to insults, threats, yelling, hitting, or pushing? ☐ Yes ☐ No

OTHER

Is there anything else that you would like for your doctor to know, or do you have any other concerns you would like addressed today?

____

____

____

____

MENTAL HEALTH

Over the past 2 weeks, how often have you been bothered by any of the following? Please Circle 0-3 for each category	**Not At All**	**Several Days**	**More than half the days**	**Nearly Every Day**
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, hopeless?	0	1	2	3
Trouble falling asleep, staying asleep or sleeping too much?	0	1	2	3
Feeling tired or having little energy?	0	1	2	3
Poor appetite or overeating?	0	1	2	3
Feeling bad about yourself- or that you're a failure or have let yourself or your family down?	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV?	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around more than usual?	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way?	0	1	2	3
If you checked off any problems, how often do these symptoms affect your work, relationships, and home life?	0	1	2	3

Over the past 2 weeks, how often have you been bothered by any of the following? Please Circle 0-3 for each category	**Not At All**	**Several Days**	**More than half the days**	**Nearly Every Day**

Feeling nervous, anxious or on edge?	0	1	2	3
Not being able to stop or control worrying?	0	1	2	3
Worrying too much about different things?	0	1	2	3
Trouble Relaxing?	0	1	2	3
Being so restless that it is hard to sit still?	0	1	2	3
Becoming easily annoyed or irritable?	0	1	2	3
Feeling afraid as if something awful might happen?	0	1	2	3

PAIN ASSESSMENT

PAIN ASSESSMENT, CPT II CODES 1125F, 1126F

In the past two weeks, how often have you felt pain?	Where is the pain?	How do you treat the pain?
☐ Almost all of the time ☐ Most times ☐ Sometimes ☐ Almost never ☐ No pain	☐ No pain **or** Mark all areas indicated on the image Right Left Left Right	☐ Medication ☐ Rest ☐ Heat or cold ☐ Therapy ☐ Other ☐ No treatment plan ☐ No pain

Rate your pain on a scale of 0-10 with 0 being no pain and 10 being the worst pain:
Circle the number on the scale

0-10 Numeric pain intensity scale

0 1 2 3 4 5 6 7 8 9 10
No Moderate Worst

MEDICATION

Please list your current medications, dosage and frequency. Please include any over the counter medications and/or vitamins you take daily. You may also provide a copy of your own and attach it to this form.

________________ ________________ ________________ ________________

______________________ ______________________ ______________________ ______________________

______________________ ______________________ ______________________ ______________________

______________________ ______________________ ______________________ ______________________

COORDINATION OF CARE

Please list any other specialist(s) that you are currently receiving care from and what they are treating you for:

Name of Specialist(s)	Treating for:	Address	Phone #	Last Date Seen

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Please list any person(s) that have permission to access your medical information and can speak to our office regarding your medical care:

Name: ______________________ **Relationship:** ______________________ **Phone#:** ______________
Name: ______________________ **Relationship:** ______________________ **Phone#:** ______________

Emergency
Contact Name: ______________________ Relationship: ___________________________ Phone#: ___________________

HIPAA

Please review

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow—up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Watertown Medical Associates, LLC of their Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to read and review the Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization's Privacy officer to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Watertown Medical Associates, LLC restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that Watertown Medical Associates, LLC are required to agree to my requested restrictions, and if agreed, then Watertown Medical Associates, LLC are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Watertown Medical Associates, LLC have taken action relying on this consent.

ACKNOWLEDGEMENT OF POLICIES

- My signature below indicates that I have reviewed and understand the HIPAA policy that was provided to me.
- By signing below, I am also giving my consent to Watertown Medical Associates, LLC for evaluation and /or treatment. Once I have been examined , I understand that I will be informed of any medically recommended diagnostic procedures and /or treatments and given the option to accept or decline.

- My signature below indicates that I authorize the release of any medical information necessary to process any claim . I authorize payment of medical benefits to the physician for services rendered.
- I understand that the treatment/service that I will be receiving from the providers at Watertown Medical Associates, LLC may not be a covered treatment/service or may not be covered at 100% by my insurance. By signing below, I acknowledge that I am responsible to contact my insurance company prior to any services ordered and/or rendered to obtain in-network and cost share information. My signature also indicated that I agree to be personally and fully responsible for any balance due.

  I am also aware that copays are due at the time of service PRIOR to being seen.
- Watertown Medical Associates, LLC has instituted a cancellation policy to better serve their patients. I am aware that if an appointment is missed, canceled or rescheduled **without a 4 hour notice, I will be charged a $25.00 fee**.If this occurs 3 or more times, I will be discharged from the practice. 2 or more consecutive cancellations of scheduled visits will also result in discharge from the practice. By signing below, I am acknowledging that I understand this policy.
- Watertown Medical Associates, LLC and Practice Fusion utilize an automated patient notification system to quickly and efficiently notify patients of their upcoming appointment. I can revoke this consent at any time. My signature below indicates that I have given Watertown Medical Associates, LLC and Practice Fusion permission to contact me via wireless telephone for automated phone calls, sms text messages and/or emails that I provided on page 1 of this intake form. I also certify that I am the owner of the wireless phone and/or email designated as the primary contact.

Name: ____________________________ **Signature:**_____________________________ **Date:** ____________

Print ***Signature***

Did someone help fill out this form for you? If so complete the following:

Persons Name:______________________________ **Persons Signature:**_______________________________ **Date:**___________

Print ***Signature***

Relationship:________________________________ **Reason:** ____