Care New England Medical Group | A MEMBER OF Care New England

Care New England Medical Group
Primary Care

1405 South County Trail | Suite 510
East Greenwich, RI 02818
(401) 736-4570 | (401) 921-6931 fax

Welcome to Care New England Medical Group Primary Care, a Patient Centered Medical Home. We are dedicated to providing you with convenient, compassionate, and comprehensive health care. In order to coordinate your health needs, please note:

- We see patients on Monday through Friday, 8:30 AM to 5:00 PM with the exception of our extended evening hours once a week till 7:00pm. Phones are answered Monday through Friday from 8:30 AM to 5:00 PM.
- We will make every attempt to answer your questions and report important test results as quickly as possible. We aim to provide you with the information and tools to help you best manage your health, including patient education and resources that will be beneficial.
- If you are ill please call us to arrange an office visit. Typically we will find an appointment for you that day or within 24 hours. If your regular physician is not available, you will be offered an appointment with another physician in the practice.
- An answering service takes your calls when the office is closed. A doctor is available 24 hours a day who will be contacted by the answering service if you need them. If you are not called back within 30 minutes, please call again and request a second page. Any life threatening issues should be called directly to 911.
- If you are unable to keep your appointment, please call our office as soon as possible so that the schedule can be changed. If you are more than 15 minutes late for your appointment, we may need to reschedule your appointment. If you miss 3 or more appointments without canceling (or rescheduling with less than 24 hours notice) we reserve the right to ask you to find another primary care provider.
- Rarely a scheduled appointment may need to be changed. In that event, we will make every effort to contact you as soon as possible to reschedule your visit to a convenient time.
- Please bring all of your insurance information with you to each visit. If you have questions about your insurance, please contact your insurance provider.
- All of your medical information and the details of your office visits are confidential and will not be shared with anyone without your consent.
- For your safety, no controlled substance will be prescribed on weekends, holidays, or after hours.
- If you are hospitalized, Care New England Medical Group Primary Care will help coordinate your medical care at Kent Hospital. We make every effort to communicate with other specialists involved in your care. If you have been hospitalized, please make sure to schedule a follow up visit when you get home. We also want to see you in the office after emergency room visits. If you see a specialist, please make them aware that we are your primary care physician and ask them to send us any results or tests.
- Copayments are expected at the time of your visit. We accept cash, checks, Visa, and Mastercard.
- Any verbal or physical abuse of the staff will be not be tolerated and will lead to dismissal from the practice.
- **If you do not show for your appointment you will be charged a $30.00 fee.**

We look forward to seeing you in our office. Please let us know what we can do for you to make your visits here pleasant and efficient. Thank you!

Welcome, the Physicians and Staff

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First Name	M.I.	Last Name	
Address	City	State	Zip
Home Phone	Work Phone	Cell #	SS#
Birth Date / Sex M F	E-Mail Address	Marital Status (circle one) S M W D Sep	Employer / Status FT/PT
If Minor, Name of Parent or Guardian	Referred By	Preferred Language (if other than English)	
Race: (circle one) White Black/African American Asian American Indian Other Unknown		Ethnicity: Hispanic Non-Hispanic Unknown	

Insurance Information (Please bring insurance card(s) with you to your appointment)

Primary Insurance Company	ID#	Group #	
Address / City	State/Zip	Subscriber's Name	
Secondary Insurance Company	ID#	Group#	
Address / City	State/Zip	Subscriber's Name	

Subscriber Information (if other than patient) – Must have SSN and DOB of subscriber

Name/ First	M.I.	Last	
Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Relationship to Patient	SS#	DOB	

Pharmacy Information

Name			
Address	City	State	Zip
Phone			

Previous Medical Provider

Name/ First	Last		
Address	City	State	Zip
Phone			

Signature: _____ **Date:** _____

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ACKNOWLEDGMENT OF DELIVERY

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Care New England Medical Group "Notice of Privacy Practices". I understand that this document describes how my medical information may be used and disclosed and how I can obtain access to the information.

_____

PATIENT NAME (Please Print) Date of Birth DATE

_____

PATIENT SIGNATURE DATE

_____

WITNESS SIGNATURE DATE

Patient unable to accept or understand the Care New England Medical Group "Notice of Privacy Practices" at this time.

Patient's Representative (Print Name): _____
Relationship to patient: _____
Patient Representatives' Signature: _____

_____ No patient representative available
_____ Patient refuses "Notice of Privacy Practices"

_____

WITNESS SIGNATURE DATE

I GIVE THE FOLLOWING INDIVIDUALS PERMISSION TO RECEIVE ANY AND ALL INFORMATION FROM MY ELECTRONIC MEDICAL RECORDS. THIS AUTHORIZATION SHALL INCLUDE CORRESPONDENCE BY TELEPHONE CONVERSATION, PRINTED RECORD, AND IN PERSON WITH THE STAFF AND/OR PROVIDERS AT CARE NEW ENGLAND MEDICAL GROUP.

_____

Name Relation Date of Birth Phone #

_____

Name Relation Date of Birth Phone #

_____

Patient Signature Date

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Patient Authorization Record

Patient Name:	Medical Record #

CONSENT TO TREATMENT:
I understand that my care will be provided according to my attending physician's orders. I understand that when I request care for my medical condition, I am generally consenting to other medical treatments such as x-ray examination, laboratory tests and minor procedures that my physician may order.

AUTHORIZATION FOR RELEASE OF INFORMATION TO PAYERS AND/OR CAREGIVERS:
I authorize Care New England Medical Group Primary Care, and any physician providing care to me, to release to any person/corporation who is or may be responsible for payment of the Physician charges.

I authorize caregivers access to my prior Care New England Medical Group Primary Care medical records which may include treatment for alcohol, drug abuse, mental illness and HIV Testing.

I understand that Care New England Medical Group Primary Care will forward copies of all or part of my medical record to physicians participating in my care, to any facility to which I am transferred, and to my insurer or to whomever is responsible for paying for my healthcare.

If my care is related to an accident at work, I understand that my employer's Worker's Compensation carrier will also have access to information contained in my medical record. Such information to be released may include, but not be limited to, diagnosis information relating to treatment of a mental illness, alcohol and/or drug abuse.

ASSIGNMENT OF BENEFITS:
I authorize my insurers to pay my benefits, which would otherwise be payable to me, directly to Care New England Medical Group Primary Care and to all the physicians providing professional services to me. I understand that I am financially responsible to Care New England Medical Group Primary Care for charges not covered by insurance carriers.

MEDICARE RECIPIENTS ONLY:
I certify that the information given by me in applying for payment of medical benefits under Title XVIII of the Social Security Act is correct.

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Healthcare Financing Administration, or it's intermediaries or carriers, any information needed for this or related Medicare claims.

I request the payment of authorized benefits to be made on my behalf to Care New England Medical Group Primary Care or any physician providing service during my treatment.

I understand that I can request a copy of the itemized bill for services rendered to me by contacting the Care New England Medical Group Primary Care.

Important message acknowledgement given to: ❒ Patient ❒ Representative _____
❒ Patient unable to accept or understand at this time (No representative available).

SIGNATURE: I have read the information above or have had it read to me. I understand the information and have had my questions answered to my satisfaction. My signature below verifies that I have voluntarily consented to the above. I have crossed out those statements that **I DO NOT AGREE** with by drawing a single line through it, placing my initials and today's date next to the statement.

Signature of Patient _____ Date/Time _____

Signature of Authorized Representative _____ Date/Time _____

Relationship to Patient _____

Reason _____
Required if patient is a minor or is unable to consent.

Signature of Witness _____ Signature of second witness _____

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Patient Name: _____ Date of birth: / /

GENERAL MEDICAL HISTORY/FAMILY HISTORY
(P=Patient, F=Family Member) Please check if you or your family has a history of:

P	F		P	F		P	F	
☐	☐	Alcoholism	☐	☐	Depression	☐	☐	Joint Pain
☐	☐	Allergies/Hayfever	☐	☐	Diabetes --on insulin	☐	☐	Kidney Infections
☐	☐	Anemia	☐	☐	Diabetes-- not on insulin	☐	☐	Kidney stone
☐	☐	Anxiety	☐	☐	Epilepsy or seizures	☐	☐	Migraine
☐	☐	Asthma	☐	☐	Fracture	☐	☐	Multiple Sclerosis
☐	☐	Irregular Heart Rhythm	☐	☐	Stomach ulcer	☐	☐	Obesity
☐	☐	Blood Transfusions	☐	☐	Gastrointestinal Disease	☐	☐	Heart Attack
☐	☐	Blocked blood vessels	☐	☐	GERD/Reflux	☐	☐	Arthritis
☐	☐	Cancer	☐	☐	Gestational (pregnancy) Diabetes	☐	☐	Osteoporosis
☐	☐	Heart Disease	☐	☐	Glaucoma	☐	☐	Pneumonia
☐	☐	Congestive Heart Failure	☐	☐	Heart Murmur	☐	☐	Lung Disease
☐	☐	Cirrhosis or liver disease	☐	☐	Hepatitis	☐	☐	Rheumatic Fever
☐	☐	Colitis	☐	☐	High Cholesterol	☐	☐	Rheumatoid Arthritis
☐	☐	COPD or emphysema	☐	☐	Hyperlipidemia	☐	☐	Sexually Transmitted Disease
☐	☐	Chronic kidney disease/dialysis	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease
☐	☐	Crohn's Disease	☐	☐	Hyperthyroidism	☐	☐	Suicide Attempt
☐	☐	Stroke	☐	☐	Hypothyroidism	☐	☐	Tuberculosis

Other Medical History:		
Hospitalizations:		
Medications:		
Drug Allergies:		Reaction:

TOBACCO ASSESSMENT

Do you smoke?	☐Yes	☐ No	How many packs per day? _____	
Have you ever smoked?	☐Yes	☐ No	How many years? _____	
Date you quit: _____				
Have you ever tried to stop?	☐Yes	☐No		

SOCIAL HISTORY

Complete the following:		**If Yes:**	**Complete the following:**	
Do you use Alcohol?	☐ No ☐Yes	__drinks per __	Educational Level	
Do you use caffeine?	☐ No ☐Yes	__ drinks per __	Marital Status (circle)	Single married separated divorced widowed
Drug Use at any time?	☐ No ☐Yes	Describe:	Exercise Habits	
IV Drug Use at any time?	☐ No ☐Yes	Describe:	Do you always wear Seatbelts?	☐ No ☐Yes
Do you use sun protection (sunscreen)?	☐ No ☐Yes		Do you have Body piercings?	☐ No ☐Yes
Do you have Tattoos?	☐ No ☐Yes		Birth Control Methods	
Are you Sexually active?	☐ No ☐Yes		Language spoken	
Gender of sexual partners	☐M ☐F		Religion	
Number of sexual partners	# _____		Occupation	

Patient Name: _____ Date of birth: / /

Race (please circle)	African/American - Asian - Ashkenazi - Caucasian - Hispanic - Mediterranean -Native American - other
Have you been abused physically?	☐ No ☐Yes
Have you been a victim of domestic violence?	☐ No ☐Yes
Any additional Social History:	

Depression Screening	
Do you have little interest or pleasure in doing things?	☐ No ☐Yes
Do you feel down, depressed or hopeless?	☐ No ☐Yes
If yes to above questions, please explain:	

OB/GYN HISTORY	
Last menstrual period:	Age periods started:
How often are periods:	Days of bleeding each cycle:
Has Menopause started?	☐ No ☐Yes If yes, what age were you:
Have you had abnormal pap smears?	☐ No ☐Yes If yes, when?
Are you sexually active?	☐ No ☐Yes If yes, Birth control method:
Any ectopic (tubal) pregnancies?	☐ No ☐Yes If yes, when?

PREGNANCY SUMMARY			
# Of Pregnancies		Miscarriage(s)	
Term		Elective Abortion(s)	
Preterm		C-Section(s):	
Live Children			
Other OB/GYN History:			

Please continue to next page

Patient Name: _____ Date of birth: / / **SURGICAL/PROCEDURAL**

☐	**No prior surgical history**	☐	D&C	☐	Hysterectomy
☐	Appendectomy	☐	Endometrial Ablation	☐	Laparoscopy
☐	Breast Lumpectomy	☐	Gall Bladder	☐	Mastectomy
☐	Cataract Surgery	☐	Heart Surgery	☐	Uterine fibroid removal
☐	Removal of Colon	☐	Hemorrhoids	☐	Removal of Ovaries
☐	Biopsy of Cervix (Cone biopsy)	☐	Hernia	☐	Tonsil/Adenoidectomy
				☐	Tubal Ligation
Other Surgical History					

PREVENTIVE CARE

TEST	DATE	TEST	DATE
Hemoglobin A1c%		HPV Vaccine	
Air Contrast Barium Enema		Last Complete Physical Exam	
Ankle Brachial Index		Lipids	
Blood Glucose		Mammography	
Bone Density		Pap Smear	
Chest X-Ray		Pneumovax	
Chlamydia Screening		PSA	
Colonoscopy		Pulmonary Function Tests	
Dilated Eye Exam		Routine Eye Exam	
DTaP Vaccine		Stool Occult Blood	
Echocardiogram		Stress Test	
Electrocardiogram		Td Vaccine (Tetanus)	
Flexible Sigmoidoscopy		Tdap Vaccine (Tetanus)	
Flu Shot		Tuberculin PPD Test	
Foot Exam Date		Chicken Pox Vaccine	
HIV Test Date		Shingles Vaccine (Zostavax)	
HPV Test Date			
Self-Management Goal			

Date completed: _____

Completed by: _____

Relationship to patient (please circle): Self Parent Child Other