Coastal Medical
ASSOCIATES

1 Wallace Bashaw Jr. Way, Suite 2003 • Newburyport, MA 01950
Tel: 978 465-0635 • Fax: 978 465-0941
www.coastalmedical.net

WELCOME TO OUR OFFICE

GENERAL INFORMATION:

Patient's name: _____ Sex: M/F Marital Status: _____

Email: _____ Pharmacy: _____ Location: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Date of Birth: _____ Social Security Number: _____ Work Phone: _____

Employer: _____ Occupation: _____

Primary Language: _____ Is interpreter needed: _____

Name of parent(s) or guardian if patient is a minor: _____

Emergency contact name: _____ Relationship to patient: _____

Emergency contact phone: (day): _____ (evening):_____

INSURANCE INFORMATION: Please present a copy of insurance card and driver's license to receptionist.

Primary Insurance Company: _____

Policy number: _____ Group number: _____ Copay: _____

Insured's name: _____ DOB: _____ Relationship to patient: _____

Secondary Insurance Company: _____

Policy number: _____ Group number: _____ Copay: _____

Insured's name:_____ DOB: _____ Relationship to patient: _____

I hereby authorize payment be made by my insurance carriers(s) directly to the physicians of Coastal Medical Associates. I acknowledge that all above information provided is true. I acknowledge that I have been made aware of the privacy policy of this office, as it pertains to the privacy and confidentiality of my medical records.

Signature: _____ Date: _____

ADDITIONAL DEMOGRAPHIC INFORMATION NEEDED

We need your help in collecting additional demographic information for quality of care improvement and to meet objectives outlined in the "meaningful use" of Electronic Health Records released by the Department of Health and Human Services. Why are physicians being urged to collect a patient's race, ethnicity and preferred language? We are collecting this data to track quality of care, health outcomes and mortality rates by relevant groups to monitor for and address disparities as well as communicate effectively with patients.

RACE	ETHNICITY	PREFERRED LANGUAGE
☐ American Indian or Alaska Native ☐ Black or African American ☐ Hispanic ☐ White ☐ Other Race ☐ Decline to Answer	☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Decline to answer	☐ English ☐ Spanish ☐ Other: _____

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HIPPA – PATIENT PRIVACY ACKNOWLEDGEMENT STATEMENT

I have been given the opportunity to read and ask questions regarding the HIPPA Privacy Notice. I understand that every effort will be made to protect my private information.

Patient Name: _____ DOB: _____

☐ Home Telephone # _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone # _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ OK to mail to my home address
- ☐ OK to mail to my work
- ☐ OK to fax to this number _____

☐ Other _____
_____

I authorize my physician's staff to leave any message relating to appointment confirmation or rescheduling on my home answering machine or with a member of my household.

☐ I authorize my physician or physician's staff to communicate and discuss my medical health and conditions including test results with the following individuals:

Name: _____Telephone #: _____ Relationship: _____

Name: _____ Telephone #: _____ Relationship: _____

Name: _____ Telephone #: _____ Relationship: _____

☐ I do not want my medical information shared with anyone.

I agree this acknowledgement is not bound by any expiration date. I understand that this acknowledgement may only be revoked or changed by myself in writing to this office.

Patient Signature: _____ Date: _____

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UNIVERSAL MEDICATION FORM

***Fold this form and keep it in your wallet or purse.**

Name:	Address:
Phone Number:	
Date of Birth:	

Allergic To/Describe Reaction:

List all prescription and over-the –counter (non-prescription) medications such as Vitamins, Aspirin, Tylenol, and Herbals (ex: Ginseng, Ginko Biloba, St. John's Wort). Include prescription medications taken as needed (ex: Viagra, Nitroglycerin).

Date	Name of Medication and Dose	Directions: Use patient friendly directions, do not use medical abbreviations	Date Stopped	Reason for taking/MD Name

UNIVERSAL MEDICATION FORM

IMMUNIZATION RECORD (Record the last dose taken)
TETANUS/TDAP:
PNEUMONIA VACCINE:
INFLUENZA VACCINE:
HEPATITIS VACCINE:

Comments:

Patients:

1. **Always keep this form with you.**

2. Take this form to ALL doctor visits and ALL medical testing (lan, x-ray, MRI, CT, etc.). Take this form to ALL pre-assessment visits for admission or surgery and ALL hospital visits (ER, in-patient admission, out-patient visits).

3. Update this form as changes are made to your medications. If a medication is stopped, draw a line through it and record the date it was stopped. If help is needed, ask a physician, nurse or pharmacist to help you fill out this form.

4. In the far right column, record the reason for taking the medication (high blood pressure, high blood sugar, ect.) and the name of the doctor who told you to take this medication. **Always keep this form with you.**

5. Tell your family, friends and neighbors about the benefits of using this form.

6. When you return to your doctor, take your dated form with you. **Always keep this form with you**. This will keep everyone up-to-date on your medications.

HOW DOES THIS FORM HELP YOU?

By using this form, it

1. **Reduces confusion and saves time.** You do not have to remember all of the medications you are taking, the form does it for you.

2. **Improves communication.** Provides doctors, health care providers and institutions with a current list of ALL of you medications. Allows the patient and/or family member to know exactly what medications are to be taken and when.

3. **Improves MEDICATION SAFETY.** Medication interactions and duplications can be detected and corrected.