RISK ASSESSMENT

Patient Name:_____ Today's Date:_____

Date of Birth:_____ Patient's Age:_____

ANEMIA Assessment	**YES**	**NO**
If your child is 4 months of age: Was your child premature or low birth weight?	○	○
If your child is 18 months of age or older: Does your child eat a vegetarian/low meat diet and not receiving an iron supplement?	○	○
ORAL Health Assessment Ages 6 months - 6years		
Does your child drink tap/filtered water?	○	○
Do you live in Wilmington or a community without Fluoride in the water? Or, is your main water supply from a private water well?	○	○
LEAD POISIONING RISK Assessment Ages 6 months - 6years		
Does your child live in or regularly visit a house/daycare that was built before 1960 and has peeling/chipping paint or plaster?	○	○
Does your child live in a house that was built before 1978 with recent, ongoing or planned renovation or remodeling of any type?	○	○
Have any of your children or their playmates/peers at their school or daycare had lead poisoning?	○	○
HIGH CHOLESTEROL/TRIGLYCERIDES RISK Assessment Ages 2 - 21 years		
Is there a family history of high cholesterol and/or triglycerides?	○	○
Is there a family history of premature cardiovascular disease? (< 55 years for men, < 65 years for women)	○	○
Is the child's BMI > 85% ?	○	○
TUBERCULOSIS RISK Assessment Ages 1 month - 21 years		
Was your child born outside of the United States?	○	○
Within the last year: Has your child lived in or travelled to Africa, Asia, Pacific Islands (excluding Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or Middle East?	○	○
Has your child been exposed to anyone with a positive TB skin test?	○	○

Consent to Treatment and Use of Health Information

Consent for Medical Treatment

I allow the healthcare providers of *Pediatric Associates of Medford* to give the patient named below medical care, including medical examinations, diagnostic testing or procedures, administration of medications, treatment, and other medical services as determined by the provider. I understand that absent emergency circumstances, major therapeutic and diagnostic procedures will not be performed unless I have had the opportunity to discuss such procedures and the risks associated therewith to my satisfaction and I have consented to such procedure. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me promising any specific result or outcome.

Release of Information for Payment and Assignment of Benefits

I agree that *Pediatric Associates of Medford* can share the patient's health information with the patient's health plan or other payment source in order to receive payment for services rendered. I hereby assign to *Pediatric Associates of Medford* the right to health insurance benefits otherwise payable to me or the patient on account of the care provided, and I authorize such medical insurance benefits to be paid directly to *Pediatric Associates of Medford*. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. A copy of this assignment and authorization may be used in place of the original.

Sharing Information Electronically

Pediatric Associates of Medford may share information electronically with other healthcare providers involved in the patient's care. Information may be shared using platforms such as the Massachusetts Health Information Highway (Mass Hlway), Massachusetts Immunization Information System (MIIS), EpicCare Link, Care Everywhere, and others. I agree that *Practice Name* can use these platforms to share the patient's medical information. I have been provided with a copy of the *Pediatric Associates of Medford* Notice of Privacy Practices that describes other uses and disclosures of health information.

Acknowledgment

This approval will remain in effect until the patient leaves *Pediatric Associates of Medford.*

Patient's Name	Patient's Date of Birth
Parent/Legal Guardian's Name (if applicable)	Relationship to Patient
Signature of Parent/Legal Guardian/Self (if 18+)	Date

Pediatric Associates of Medford
Social History

Date:
Patient Name & Date of Birth:
Form Completed by:

Please answer the following questions to help us learn about your child's environment. Please be advised the information obtained will be kept confidential.

Do both parents live in the household?

Does your family live in a house or apartment?

What languages are spoken in home?

Does your child attend daycare? In what type of setting?

Are there any guns or ammunition in the home?

Are there any pets in the home, if yes what type?

What type of work do adult household members do?

Where does your water supply come from: i.e., city, well? Does it contain fluoride?

Does anyone in the home use tobacco/smoke?

Does anyone in the home use/used illegal drugs?

Does anyone in the home use/used alcohol in excess?

Are there any concerns about safety or violence in the home?

Is or has the Department of Children and Families (DSS/DCF) been involved with anyone in the home?

PEDIATRIC ASSOCIATES OF MEDFORD, P.C.
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
FOR PATIENTS 18 YEARS OF AGE OR OLDER

Patient Name:_____ Date of birth:_____

Pediatric Associates of Medford keeps medical records confidential. However, at times we may want to share your information with other people – for example, to let your school know about an illness or treatment, or to update another doctor or specialist. In most cases, we need your permission to share this information. We share only the information that is needed, not the whole medical record.

Part I: Please read the following paragraphs. Pick the one which fits you best, and write your initials in either box A, B, or C. You must pick one of the following.

A: [ ] I give Pediatric Associates of Medford permission to share my medical information with the people/groups listed in Part II below. This may include appointment information; information about immunizations; information about pregnancy, birth control, STD testing, and treatment; or basic information about mental health counseling. This release does NOT authorize Pediatric Associates of Medford to give information regarding HIV testing, treatment, or status; drug or alcohol abuse diagnosis or treatment; inpatient mental health services; or details of mental health counseling or psychotherapy.

B: [ ] I give Pediatric Associates of Medford permission to share medical information as described in paragraph A, with the people/groups listed in Part II below. **However, I want the following information kept private:**

_____

_____

_____

C: [ ] I do **NOT** give Pediatric Associates of Medford permission to share **ANY** of my medical information as described in paragraph A. **Please know that we cannot speak with your parent or guardian to book appointments or refill medications if you do not allow us to share at least some of your medical information with them.**

Part II: The following people/groups may have access to my personal health information. People listed in this section must be over the age of 18. Please understand that all information described in the paragraph you initialed above (either A or B) can be shared with the people or groups you include in this section.

[ ] My school: _____

School phone number: _____

[ ] My parent/guardian(s): _____

Parent phone number(s): _____

[ ] Others (please specify): _____

_____

Please complete both sides of this form

PEDIATRIC ASSOCIATES OF MEDFORD, P.C.
CONSENT TO COMMUNICATE WITH PATIENT

We would like to know the best ways for us to contact you.
Please read each of the following statements. If you agree, write your initials in the box provided.

[ ] Pediatric Associates of Medford may **call my home phone number and leave a message** on voice mail. This may include appointment reminders, insurance information, and any call about my care, including laboratory results. **My home phone number is:**_____

[ ] Pediatric Associates of Medford may **call my cell phone number and leave a message** on voice mail. This may include appointment reminders, insurance information, and any call about my care, including laboratory results. **My cell phone number is:**_____

[ ] Pediatric Associates of Medford may **mail letters to my home address**. This may include appointment reminders, insurance information, and any call about my care, including laboratory results. **Please know we can only keep one home address on your medical record.**

PEDIATRIC ASSOCIATES OF MEDFORD, P.C.
NOTICES AND EXPLANATION OF RIGHTS

I understand that Pediatric Associates of Medford may share my information with certain people or groups for purposes of treatment, billing, and payment, or as otherwise required by law, *without* having to ask my permission. More information about this can be found in the Notice of Privacy Practices, which I have had a chance to read before signing this form.

I understand that I may change my mind and decide I do not want Pediatric Associates of Medford to share my information as described above. This is called a revocation. I understand that I may create a revocation by writing to: Medical Records Department, Pediatric Associates of Medford, 101 Main Street, Suite 201, Medford, MA 02155.

Once the Medical Records Department of Pediatric Associates of Medford receives my written revocation, the office will stop sharing my information from that point on. I understand that this cannot apply to information Pediatric Associates of Medford may have released in the past.

I understand that I have the right to refuse to sign this authorization. I understand that Pediatric Associates of Medford may not deny me treatment just because I choose not to sign this authorization.

I understand that if Pediatric Associates of Medford shares my information with a person or organization that is not legally required to keep it confidential, the information may be shared again by that person or organization and no longer be protected.

I understand that I have a right to receive a copy of this signed authorization., and that this authorization will last one year from the date below.

Signature of Patient: _____ Date:_____

Patient Name: _____

Please complete both sides of this form