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 FROM BIRTH THROUGH AGE 17

Patient Name:_____ Date of birth:_____

Pediatric Associates of Medford keeps medical records confidential. However, at times we may wan share your child's information with other people – for example, to notify your child's school of illne: treatment, or provide additional treatment or referrals. This may require disclosing some of your chi confidential medical information to others. In some cases, we need your permission to share this information. We will share the minimum amount of information necessary to accomplish these purpo

It is important to note that patients 15 and older may consent to receive certain health care services on their own, often called "minor consent" services. Some examples of "minor consent" services include mental health counseling, treatment for addiction, diagnosis and treatment of sexually transmitted diseases, and contraception. **Please refer to our Adolescent Confidentiality Policy for further information regarding how Pediatric Associates of Medford handles this type of protected health information.**

Part I: Please read the following paragraphs closely, then initial either box A or B below:

A: [ ] I give Pediatric Associates of Medford permission to share or disclose medical records and medical information related to care that I consented to for my child with the persons and agencies specified under Part II below. This may include contact and appointment information, information about immunizations, or basic progress or diagnosis information about mental health counseling. **This release does NOT authorize Pediatric Associates of Medford to disclose information regarding HIV testing treatment, or status; drug or alcohol abuse diagnosis or treatment; inpatient mental health services details of mental health counseling; or psychotherapy notes.**

B: [ ] I give Pediatric Associates of Medford permission to share or disclose all medical records and information as described in the paragraph above with the persons and agencies specified under Part II below, **except the information indicated below**. Pediatric Associates of Medford must have a separate authorization from me to disclose the information I describe on these lines.

_____

_____

_____

Part II: Pediatric Associates of Medford may share this information with the following persons and agencies (please initial your consent in the box provided, indicating the specific name(s) of each, and whether this person is able to accompany the patient for medical treatment by circling yes or no):

[ ] Other parent/guardian: _____ Yes No

[ ] Other responsible adult(s): _____ Yes No

_____ Yes No

_____ Yes No

[ ] My child's school: _____

Please complete both sides of this form

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

[ ] Pediatric Associates of Medford may **call my home phone number** and leave a message on voice mail in reference to any item to assist the practice in carrying out treatment, payment, or health care operations. This may include appointment reminders, insurance information, and any call pertaining to my child's clinical 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 in reference to any item to assist the practice in carrying out treatment, payment, or health care operations. This may include appointment reminders, insurance information, and any call pertaining to my child's clinical care, including laboratory results. **My cell phone number is:**_____

[ ] Pediatric Associates of Medford **may mail to my home address** any item to assist the practice in carrying out treatment, payment, or health care operations. This may include appointment reminders, insurance information, and any call pertaining to my child's clinical care, including laboratory results.

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

I understand that Pediatric Associates of Medford may share or be required to share my child's health ca information with certain persons or agencies for purposes of treatment, health care operations, and billin and payment, or as otherwise required by law, without having to ask my permission or needing a signed authorization. Further information about these uses can be found in the Notice of Privacy Practices, which I have had a chance to review before signing this form.

I understand that I may change my mind and decide I do not want Pediatric Associates of Medford to disclose my child's information as described above. This is called a revocation. I understand that I may revoke this authorization 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 notice o revocation, the office will stop sharing my child's information from that point on. I understand that revocation does not apply to information Pediatric Associates of Medford may have released previousl

I understand that I have the right to refuse to sign this authorization. I understand that Pediatric Associ of Medford may not deny my child treatment or eligibility for benefits just because I choose not to sig this authorization.

I understand that if Pediatric Associates of Medford discloses my child's information to a person or organization that is not legally required to keep it confidential, the information may be redisclosed by 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 authorizati will last one year from the date below.

Signature of Parent/Guardian: _____ Date:_____

Please complete both sides of this form