# THOMPSON MEDICAL ASSOCIATES

*Internal Medicine and Concierge Medicine*

Dear new Patient,

Good day!

Welcome to Thompson Medical Associates!

We are excited to welcome you to our practice and thank you for choosing our physicians to participate in your healthcare journey. We look forward to providing you with personalized, comprehensive care focusing on wellness and prevention.

***Please note:*** The New Patient Packet should only be filled out if you have already been accepted or have spoken with someone from our office who has confirmed your status as a patient. Once completed, kindly return the packet to us as soon as possible so we can schedule your initial appointment.

We look forward to partnering with you in your health care!

Thank you!

Dr. Candace Thompson / Amy Lane, PA

9F Dr. Osman Babson Road
Gloucester MA 01930
Mill Pond Complex

(978)-890-7373
www.thompsonmedicalessex.com
email@thompsonmedicalessex.com

# THOMPSON MEDICAL ASSOCIATES

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Name: _____

Address: _____

_____

Phone: _____ Alternative Phone: _____

Pharmacy: _____

Email: _____

DOB: _____ Sex: MALE FEMALE OTHERS: _____

Employment Status / Company: _____

Full time / part time / self-employed / retired / student / child / unemployed

Language: English Ethnicity: non-hispanic Race: caucasian

Marital status: Single / Married / Widowed / Other

Spouse if applicable: _____

Guarantor information / party responsible for payment: same as patient

Primary Insurance: _____

Insurance ID #: _____ Group ID # (if applicable): _____

Secondary Insurance: _____

Insurance ID #: _____ Group ID # (if applicable): _____

Emergency Contact: _____

Phone: _____ Relationship: _____

Secondary Emergency Contact: _____

Phone: _____ Relationship: _____

If above is correct, please sign: _____

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MEDICATIONS: list dose and times per day (also list over the counter medications such as aspirin and multivitamins or herbals)

_____

_____

_____

_____

_____

ALLERGIES OR SENSITIVITIES TO MEDS OR FOODS:

_____

_____

_____

HOSPITALIZATIONS OR SURGERIES AND YEAR:

_____

_____

_____

HAVE YOU HAD A COLONOSCOPY? Y N If YES, what year: _____

SOCIAL HISTORY:

SINGLE MARRIED DIVORCED WIDOWED OTHER _____

Children: _____

NONSMOKER QUIT YEAR _____ SMOKER _____ PACK PER DAY

VAPE: Y N QUIT YEAR _____ CHEWING TOBACCO: Y N

ALCOHOL USE: _____ PER DAY / WEEK / MONTH

CAFFEINE USE: _____ PER DAY

EXERCISE: _____ MINUTES PER DAY / WEEK

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## MEDICAL HISTORY FORM

Name: _____ DOB: _____

*NOTE ALL INFORMATION YOU WRITE IS CONFIDENTIAL*

## PAST MEDICAL HISTORY

_____

_____

_____

_____

_____

### Please circle any past medical conditions:

| | | | | |
|---|---|---|---|---|
| Asthma | Alcoholism | Anemia | Arthritis | Lyme Disease |
| Blood in Stool | COVID-19 | Cancer | Jaundice | Rash |
| Diabetes | Emphysema | COPD | Glaucoma | Hypertension |
| Gout | Heart Disease | Hepatitis | Hernia | Suicide Attempt |
| Kidney Disease | Substance Abuse | Migraine | Edema | Pacemaker |
| Pneumonia | Venereal Disease | Liver Disease | Bronchitis | Rheumatic Fever |
| Scarlet Fever | Stroke / CVA | TB | Thyroid Disease | Stomach Ulcer |
| High Cholesterol | CHF | HIV | Chemotherapy | Urinary Issues |
| Mental Health Disorder: | | | | |

### Please circle any that apply:

| | | | | |
|---|---|---|---|---|
| Fever | Wheezing | Sore Throat | Urinary Frequency | Cough |
| Night Sweats | Nausea | Fatigue | Swelling in Joints | Headaches |
| Numbness | Vomiting | Chest Pain | Changes in Bowels | Weakness |
| Constipation | Trouble Walking | Weight Change | Change in Appetite | Abdominal Pain |
| Blood in Urine | Seizures | Skin Rash | Muscle Weakness | Chills |
| Moles | Fainting | Dizziness | Shortness of Breath | Change in Vision |

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FOR MEN ONLY:

Any testicular lumps? Y N

Prostate issues? Y N

Urinary issues? Y N

Sexual problems or erectile problems? Y N

Last PROSTATE Exam: _____

FOR FEMALES ONLY:

Age menses started: _____ Date of last menses? _____

Menopause? Y N if Yes, year: _____

Changes in menses? Problems with menses? Nipple discharge? Breast lump?

Y N Explain: _____

Do you have an OBGYN doctor? If yes, who? _____

Last MAMMOGRAM: _____ Abnormal? Y N

Last BONE DENSITY / DEXA: _____ Abnormal? Y N

Last PAP SMEAR: _____ Abnormal? Y N

If you have had pregnancies, how many? _____ Live births? _____

Twins/multiple? _____ Miscarriage? _____ Abortions? _____

C-sections? _____

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Do you own firearms? Y N

Do you feel safe in your home? Y N

Do you wear seat belts always? Y N

Do you wear sunscreen always? Y N

Drug use, past or present: _____

Profession / Occupational hazards: _____

FAMILY HISTORY: Please notate if alive and any diseases such as cancer, diabetes, heart disease, stroke, high blood pressure, high cholesterol, etc.

MOTHER: _____

FATHER: _____

SIBLINGS: _____

GRANDPARENTS: _____

OTHERS: _____

SPECIALIST:

Do you see any specialist doctors? If yes, who do you see and for what reason?

_____

_____

_____

_____

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# THOMPSON MEDICAL ASSOCIATES

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## THOMPSON MEDICAL ASSOCIATES, LLC

## MEDICAL CONSENT TO TREAT, PRIVACY AND PAYMENTS

Medical consent:

By signing this document, I allow Dr Candace Thompson, DO and other practitioners at Thompson Medical Associates, 9 E Doctor Osman Babson Road to examine for well and sick visits, diagnose, treat and record any and all medical illness allowed under her medical license in the state of Massachusetts as allowed as an Internal Medicine Doctor. In addition, I agree to allow Thompson Medical Associates to communicate using automated messages, phone calls, text messages, emails, and voice messages.

Payments:

I further allow her to charge my insurance company for any and all covered services rendered. In the event I have a copayment, deductible or non-covered insurance cost, I will be responsible for payments. If I have no insurance, payment will be expected at time of visit.

HIPAA:

In accordance to the law, HIPAA or Health Insurance Portability and Accountability Act was offered to me to read to take home. I understand my privacy rights in this office.

GUARDIAN / MINOR:

Also by signing this, if there needs to be a guardian signature, all apply above for patient if guardian signs for them.

Name: _____

Signature: _____

Date: _____

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# Your Office Visit and Charges

## When Will I Have To Pay?

We will request your co-payment when you check in for a visit. We will send you a bill if there is an unpaid balance after we receive payment for your visit from your insurance company.

It is import that you understand your health insurance benefits. You are **responsible for understanding your plan.** We can not keep track of all the plans as they vary greatly.

**We encourage you to contact your health insurance plan. Beware of all that your plan covers and does not cover. Beware of deductibles.**

**In the course of a physical/well/preventive visit, you may be treated for a separate problem. Depending upon your benefits, your insurance plan may require that you pay additional charges for the added services rendered at the same time.**

The insurance company wants us to bill for the physical and then bill for the problem or "sick" on the same day.

X_____DATE_____

**By signing, I acknowledge the above**