Newton Wellesley Surgeons, Inc.
2000 Washington Street
Green Building, Suite 365
Newton, MA 02462
Phone: 617-244-5355
Fax: 617-244-8662
www.nwsurgeons.com

Morton G. Kahan, MD
P. VonRyll Gryska, MD
Joanna M. Sentissi, MD
Michael Reinhorn, MD
Deborah R. Schnipper, MD
Tammy M. Holm, MD
Lauren R. Ott, PA-C

Welcome to Newton Wellesley Surgeons, Inc. We are looking forward to having you as a patient. Your health and well-being are our primary concerns and our goal is to make your appointment as easy and pleasant as possible.

In order to expedite your visit, please complete the attached forms and return them to our office on or before your appointment. When you come to your appointment please bring a copy of your insurance card and a current Photo ID.

Your insurance carrier assigns you the responsibility to know if you need a referral, have co-Pays, deductibles, or co-Insurance payments. We will help you in any way that we can in providing you with information. A referral is obtained from your Primary Care Physician and needs to be faxed to us prior to your visit. If your insurance requires a referral please call this office two days before your appointment to confirm that one is in place.

Please note: Your Co-Pay is due in full at the time of each visit. You may pay using cash, check or credit card. Please contact us with any questions you may have in advance of your visit. We are here to assist you and look forward to welcoming you to our practice.

Sincerely,
Physicians & Staff of Newton Wellesley Surgeons

Please arrive 15 Minutes early to allow adequate time for registration.

** Please be advised that **Newton Wellesley Surgeons** requires 48 hours' notice to cancel an appointment. We reserve the right to charge $50 for a missed clinic appointment that was not* Cancelled in advance, thank you.

NEWTON WELLESLEY SURGEONS, INC.

PATIENT RIGHTS & RESPONSIBILITIES

1. The patient shall be afforded considerate and respectful care.
2. Upon request, the patient shall be furnished with the name of the physician and/or certified registered nurse practitioner responsible for coordinating his/her care.
3. Upon request, the patient shall be furnished with the name of the physician or other person responsible for conducting any specific test or other medical procedure performed in connection with the patient's treatment.
4. The patient shall have the right to refuse any treatment to the extent permitted by law.
5. The patient's right to privacy shall be respected to the extent consistent with providing adequate medical care to the patient and with the efficient administration of the provider. Nothing in this section prohibits discreet discussion of a patient's case or examination by appropriate medical personnel.
6. The patient's right to privacy and confidentiality shall extend to all records pertaining to the patient's treatment except as otherwise provided by law. (See the Notice of Privacy Practices for more information about the privacy of the medical information.)
7. If the provider proposes to use the patient in any human experimentation project, it shall first thoroughly inform the patient of the proposal and offer the patient the right to refuse to participate in the project.
8. Upon request, the patient shall be allowed to examine and shall be given an explanation of the bill irrespective of the source of payment of the bill.
9. Upon request, the patient shall be permitted to examine any pertinent provider rules and regulations that specifically govern the patient's treatment.
10. The patient shall be offered treatment without discrimination as to race, color, creed, national origin, gender, religion, source of payment, sexual orientation, age, gender identity or expression, handicapping condition or degree of handicap.
11. Patients shall be provided with a summarized medical bill within thirty (30) days of receiving services from provider. Upon request, the patient shall be furnished with an itemized copy of his or her bill.
12. No charge shall be made for furnishing a health record or part of a health record to a patient, his or her attorney or authorized representative if the record or part of the record is necessary for the purpose of supporting an appeal or claim related to the Social Security Act, the Workers' Compensation Act, or any federal or state needs-based benefit program such as Medical Assistance, RIte Care, Temporary Disability Insurance (TDI) or unemployment compensation. The provider shall furnish a health record requested pursuant to this section within thirty (30) days of the request.

13. The patient shall have the right to have his or her pain assessed on a regular basis.
14. The provider shall provide the patient/family with written information concerning its policies on advance directives, including a description of any applicable state law.

The patient is responsible for:

1. Being considerate of other patients and personnel and for assisting in the control of noise and other distractions.
2. Respecting the property of others and the provider.
3. Reporting whether he/she clearly understands the planned course of treatment and what is expected of him/her.
4. Keeping appointments and, when unable to do so for any reason, notifying the provider.
5. Providing personnel with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in condition or any other health matters.
6. Observing prescribed rules of the provider during his/her treatment.
7. Promptly fulfilling his/her financial obligations to the provider.

NEWTON WELLESLEY SURGEONS, INC.

NAME: _____ DATE OF BIRTH: _____

PRIMARY CARE DOCTOR: _____

REFERRING DOCTOR: _____

REASON FOR VISIT: _____

MEDICAL HISTORY:

Medical Problem ***Year Diagnosed*** ***Physician***

1._____
2._____
3._____
4._____
5._____

SURGICAL HISTORY:

Operation or Hospitalization ***Year*** ***Hospital*** ***Physician***

1._____
2._____
3._____
4._____
5._____

CURRENT MEDICATIONS:

Name ***Dosage***

1._____
2._____
3._____
4._____
5._____

ALLERGIES:

1._____
2._____
3._____
4._____

DO YOU SMOKE? **•YES • NO** IF YES HOW MUCH:_____

DO YOU DRINK ALCOHOL? IF YES HOW MUCH:_____

OCCUPATION: _____

FAMILY HISTORY OF CANCER:

WHO: _____ TYPE:_____

WHO: _____ TYPE:_____

PLEASE COMPLETE REVERSE SIDE

YES	CONSTITUTION	NO	YES	EYES	NO	YES	ENDOCRINE	NO	YES	ALLERG / IMMUNO	NO
	Activity Change			Eye discharge			Cold intolerance			Environmental allergies	
	Appetite Change			Eye itching			Heat Intolerance			Food allergies	
	Chills			Eye pain			Polydipsia *(Thirsty)*			Immunocompromised	
	Diaphoresis			Photophobia			Polyphagia *(Hungry)*			**NEUROLOGICAL**	
	Fatigue			*(Light Sensative)*			Polyuria *(Lots of urine)*			Dizziness	
	Fever			Visual disturbances			**GU**			Facial asymmety	
	Unexpected			**RESPIRATORY**			Difficulty urninating			Headaches	
	weight change			Apnea			Dyspareunia *(Intercourse pain)*			Light-headedness	
	HENT			Chest tightness			Dysuria *(Urination pain)*			Numbness	
	Facial swelling			Choking			Enuresis *(Involuntary urination)*			Seizures	
	Neck pain			Cough			Flank pain			Speech difficulty	
	neck stiffness			Shortness of breath			Frequency			Syncope	
	Ear discharge			Stridor *(Vibrations)*			Genital sore			Tremors	
	Hearing Loss			Wheezing			Hematuria *(Blood in urine)*			Weakness	
	Ear Pain						Incontinence *(Bladder)*			**HEMATOLOGIC**	
	Tinnitus *(Ringing)*			**CARDIOVASCULAR**			Menstrual problem			Adenopathy	
	Nosebleeds			Chest pain			Nocturia *(Night Urination)*			*(Inflammation of glands)*	
	Congestion			Leg swelling			Pelvic pain			Bruises/bleeds easily	
	Rhinorrhea *(Nose)*			Palpitations			Urgency			**PSYCHIATRIC**	
	Postnasal drip						Urine decreased			Agitation	
	Sneezing			**GI**			Vaginal bleeding			Behavior problem	
	Sinus pressure			Abd distention			Vaginal discharge			Confusion	
	Dental problem			Abdominal pain			Vaginal pain			Decreased concentration	
	Drooling			Anal bleeding			**MUSC**			Dysphoric mood *(Uneasy)*	
	Mouth Sores			Blood in stool			Arthralgias *(Joint pain)*			Hallucinations	
	Sore Throat			Constipation			Back pain			Hyperactive	
	Trouble swallowing			Diarrhea			Gait problem *(Walking)*			Nervous / anxious	
	Voice change			Heartburn			Joint swelling			Self-injury	
				Nausea			Myalgias *(Muscle pain)*			Sleep disturbance	
				Rectal pain			**SKIN**			Suicidal ideas	
				Vomiting			Color change				
							Pallor *(Pale color)*				
							Rash				
							Wound				