

Certified Medical Assistant (CMA) Baseline Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. During a patient intake, which of the following is most important to verify?**
 - A. Emergency contact information**
 - B. Patient's insurance information**
 - C. Patient's medical history**
 - D. Patient's preferred pharmacy**

- 2. What can result from using outdated or incorrect codes on a billing claim?**
 - A. Increased patient satisfaction**
 - B. Reduction of payer reimbursement**
 - C. Improved claim approval rate**
 - D. Faster processing time**

- 3. What is the purpose of applying pressure after completing a venipuncture?**
 - A. To prevent swelling**
 - B. To decrease pain**
 - C. To promote clotting and prevent bleeding**
 - D. To ensure sample integrity**

- 4. Which section of clinical medical records contains the patient's subjective data obtained during the clinical intake process?**
 - A. Health history**
 - B. Physical examination results**
 - C. Diagnostic tests**
 - D. Treatment plan**

- 5. If a medical assistant is exposed to an infectious disease via a human bite, what should they do first?**
 - A. Report the incident to a supervisor.**
 - B. Immediately flush the exposed area following the exposure.**
 - C. Apply an antibiotic ointment.**
 - D. Wait for symptoms to appear.**

- 6. Which of the following is recognized as a CLIA-waived laboratory test?**
- A. Blood glucose test**
 - B. Human chorionic gonadotropin (hCG) test**
 - C. Lipid panel**
 - D. Complete blood count**
- 7. What measurement should be taken to determine if a child has microcephaly during a routine exam?**
- A. Height**
 - B. Weight**
 - C. Head circumference**
 - D. Arm span**
- 8. At what age should patients receive the Tetanus, diphtheria, and pertussis (Tdap) vaccine?**
- A. 5 years**
 - B. 7 years or older**
 - C. 12 years**
 - D. 15 years**
- 9. What is a crucial step in ensuring patient safety during medication administration?**
- A. Verify the medication with another nurse**
 - B. Document the administration immediately**
 - C. Check the patient's ID before administration**
 - D. Educate the patient about the side effects**
- 10. Which document is required when billing a patient's third-party payer for an office visit?**
- A. Encounter form**
 - B. 837P/CMS-1500 claim form**
 - C. Patient information sheet**
 - D. Superbill**

Answers

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1. C
2. B
3. C
4. A
5. B
6. B
7. C
8. B
9. C
10. B

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Explanations

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1. During a patient intake, which of the following is most important to verify?

- A. Emergency contact information**
- B. Patient's insurance information**
- C. Patient's medical history**
- D. Patient's preferred pharmacy**

Verifying the patient's medical history is critical during intake because it provides essential information about the patient's past health issues, allergies, medications, and treatments. This information directly impacts the care and treatment decisions made by healthcare providers. Having an accurate medical history helps ensure that any potential drug interactions, allergies, or relevant chronic conditions are considered, minimizing the risk of adverse events during diagnosis or treatment. While the other options, such as emergency contact information, insurance information, and preferred pharmacy, are also important for patient care and administrative purposes, they do not directly influence clinical decision-making to the same extent as medical history does. Verifying the medical history lays the foundation for understanding a patient's health status and needs, making it the most crucial aspect to confirm during the intake process.

2. What can result from using outdated or incorrect codes on a billing claim?

- A. Increased patient satisfaction**
- B. Reduction of payer reimbursement**
- C. Improved claim approval rate**
- D. Faster processing time**

Using outdated or incorrect codes on a billing claim can indeed lead to a reduction of payer reimbursement. Accurate coding is essential in the healthcare industry as it directly impacts the amount that providers are reimbursed for their services. If incorrect codes are used, insurance companies may deny the claim or pay a lower amount, leading to financial losses for the healthcare provider. This not only affects the revenue cycle but may also necessitate additional work to correct and resubmit claims, further complicating the billing process. In contrast, the other options would not typically arise from using outdated or incorrect codes. Increased patient satisfaction and improved claim approval rates are unlikely outcomes, as coding errors can lead to frustrations for both patients and providers. Additionally, the processing time for claims may actually lengthen when errors are present, as claims need to be investigated or corrected. Therefore, using accurate and up-to-date codes is crucial for maintaining the financial health of healthcare practices.

3. What is the purpose of applying pressure after completing a venipuncture?

- A. To prevent swelling**
- B. To decrease pain**
- C. To promote clotting and prevent bleeding**
- D. To ensure sample integrity**

Applying pressure after completing a venipuncture serves the critical purpose of promoting clotting and preventing bleeding. When a needle is inserted into a vein, it creates a small wound. Removing the needle can leave the puncture site vulnerable to bleeding, especially if the patient has issues related to blood clotting or if the venipuncture was performed on a larger vein. By applying pressure directly to the site, you help encourage the blood to clot at the puncture site. The application of pressure can assist in sealing the opening in the vein and initiate the body's natural clotting process. This action decreases the risk of significant bleeding and helps prevent the formation of a hematoma, which is a collection of blood outside of blood vessels. Other considerations, such as preventing swelling and ensuring sample integrity, are important, but they are secondary effects of proper technique and post-venipuncture care. The most direct and immediate reason for applying pressure is to manage bleeding effectively.

4. Which section of clinical medical records contains the patient's subjective data obtained during the clinical intake process?

- A. Health history**
- B. Physical examination results**
- C. Diagnostic tests**
- D. Treatment plan**

The health history section of clinical medical records is where the patient's subjective data is documented. This section includes information that the patient provides about their medical history, symptoms, concerns, and feelings regarding their health. It captures the patient's personal account of their condition, which is essential for understanding their medical background and current health status. In contrast, the physical examination results section consists of objective data gathered by the healthcare provider during the examination, such as vital signs, physical findings, and observations. Diagnostic tests refer to the results from laboratory tests or imaging studies used to diagnose medical conditions. The treatment plan outlines the recommended interventions and therapies based on the data collected but does not include subjective information directly from the patient. Thus, the health history is the correct response, as it specifically contains the subjective data that the patient shares during the intake process.

5. If a medical assistant is exposed to an infectious disease via a human bite, what should they do first?

A. Report the incident to a supervisor.

B. Immediately flush the exposed area following the exposure.

C. Apply an antibiotic ointment.

D. Wait for symptoms to appear.

The most appropriate initial action when a medical assistant is exposed to an infectious disease via a human bite is to immediately flush the exposed area following the exposure. Thoroughly cleansing the wound with soap and water is crucial because it helps to remove any potential pathogens from the surface of the skin. This immediate response can significantly reduce the risk of infection and the transmission of any disease that might be present in the saliva of the person who inflicted the bite. Following flushing the area, it is also important to seek further medical advice for potential follow-up care, such as the need for additional treatments or vaccinations, but the immediate focus should be on cleaning the wound effectively.

6. Which of the following is recognized as a CLIA-waived laboratory test?

A. Blood glucose test

B. Human chorionic gonadotropin (hCG) test

C. Lipid panel

D. Complete blood count

The human chorionic gonadotropin (hCG) test is recognized as a CLIA-waived laboratory test due to its simplicity, low risk for incorrect results, and the fact that it can be performed in a physician's office or other non-traditional laboratory settings. CLIA, or the Clinical Laboratory Improvement Amendments, categorizes laboratory tests based on their complexity. Waived tests are the least complex and are designed to be performed with minimal training, making them suitable for settings where traditional laboratory facilities may not be available. Blood glucose tests, while often simple and widely used, can vary in complexity based on the method used and the devices employed. For instance, certain glucose testing methods may not qualify as waived due to the need for more stringent quality control. Lipid panels and complete blood counts are considered more complex tests that require specific procedures, equipment, and often the interpretation of results by trained laboratory personnel. These types of tests typically fall into higher complexity categories under CLIA regulations, thus are not classified as waived tests.

7. What measurement should be taken to determine if a child has microcephaly during a routine exam?

- A. Height**
- B. Weight**
- C. Head circumference**
- D. Arm span**

To determine if a child has microcephaly during a routine exam, measuring head circumference is essential. Microcephaly is a condition characterized by an abnormally small head size, which can be indicative of underlying developmental issues. The head circumference measurement provides direct insight into the growth and development of the child's brain and skull relative to expected norms for their age and sex. Height and weight measurements are critical for assessing a child's overall growth and nutritional status, but they do not directly evaluate brain size. Similarly, arm span measurements are not relevant when diagnosing microcephaly, as they pertain more to the assessment of skeletal growth rather than head development. Hence, head circumference is the specific measurement used to identify cases of microcephaly.

8. At what age should patients receive the Tetanus, diphtheria, and pertussis (Tdap) vaccine?

- A. 5 years**
- B. 7 years or older**
- C. 12 years**
- D. 15 years**

The recommended age for administering the Tetanus, diphtheria, and pertussis (Tdap) vaccine is 7 years or older. This is typically when patients transition from the childhood immunization schedule to the adolescent vaccination guidelines. The primary vaccination series for these diseases is usually completed in early childhood, but a booster dose is crucial to ensure continued protection against these potentially serious infections as the individual grows older. The Tdap vaccine is particularly important to administer around ages 11 to 12, as this is a critical period in adolescence when immunity from childhood vaccinations may begin to wane. Moreover, receiving the Tdap vaccine at this age helps protect not only the individual but also the community by preventing the spread of these diseases, especially pertussis, which can be particularly dangerous for infants. By ensuring that adolescents receive this vaccine, healthcare providers are helping to maintain high levels of immunity in the community and reduce the incidence of these preventable diseases.

9. What is a crucial step in ensuring patient safety during medication administration?

- A. Verify the medication with another nurse**
- B. Document the administration immediately**
- C. Check the patient's ID before administration**
- D. Educate the patient about the side effects**

Checking the patient's ID before medication administration is a crucial step in ensuring patient safety. This process helps confirm that the right patient is receiving the correct medication, thereby minimizing the risk of medication errors. Identifying patients accurately prevents potentially serious consequences, such as administering medications to the wrong individual, which can lead to adverse reactions or ineffective treatment. While verifying the medication with another nurse, documenting the administration, and educating the patient about side effects are important facets of medication management and promote overall safety in a healthcare environment, they do not directly address the immediate and critical need to correctly identify the patient at the moment of administration. Ensuring the individual's identity aligns with the prescribed treatment is foundational in patient care and serves as the first line of defense against medication errors.

10. Which document is required when billing a patient's third-party payer for an office visit?

- A. Encounter form**
- B. 837P/CMS-1500 claim form**
- C. Patient information sheet**
- D. Superbill**

The 837P/CMS-1500 claim form is essential when billing a third-party payer for an office visit because it is the standard format used to submit claims for payment for medical services rendered. This form contains critical information related to the patient, the services provided, diagnosis codes, and billing details. Ensuring that all relevant information is accurately reported on this form is crucial for the timely processing and reimbursement of the claim by insurers. The encounter form, while useful for gathering information during the office visit, does not serve as a billing document itself. A patient information sheet typically collects personal and demographic details but is not used for billing purposes. Similarly, a superbill, although it may summarize services provided, is more for internal use and requires conversion to the claim format, which is accomplished using the CMS-1500 form for third-party billing. The 837P/CMS-1500 claim form is thus the correct document needed to initiate the billing process with a patient's insurance provider.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://cmabaseline.examzify.com>

We wish you the very best on your exam journey. You've got this!

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