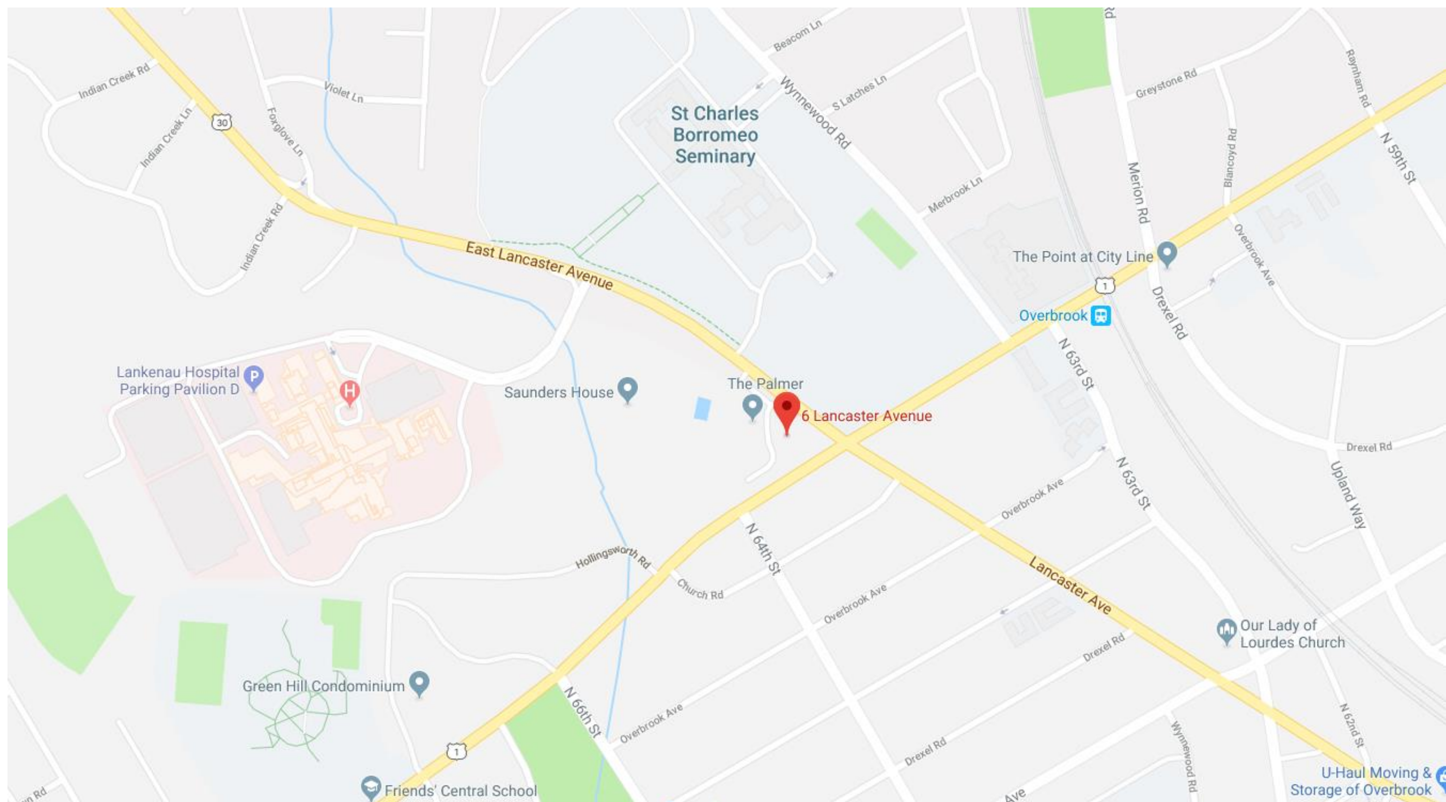
New Patient Reminder

Please bring to your appointment:

1. Photo ID
2. Insurance Cards
3. All Medication Bottles/Inhalers/Vitamins/OTC medications
    - Do **not** bring a list.
    - Bringing in your bottles helps prevent medication errors.



BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION

Patient Registration Form

PLEASE PRINT CLEARLY Date ________________ Account Number ______________________

PATIENT INFORMATION				
Patient's Last Name: First Name: Middle Initial:			Date of Birth:	Sex: ❑ Male ❑ Female
Patient's Street Address:				Marital Status: ❑ S ❑ M ❑ D ❑ W
City:	State, ZIP:	Patient's Home Phone #:	Patient's Cell Phone #:	
Billing Street Address of Responsible Party (if different from above):		Race: ❑ African-American ❑ Asian ❑ Caucasian ❑ Other Ethnicity: ❑ Hispanic ❑ Non-Hispanic		
City:	State, ZIP:	Primary Language: ❑ English ❑ Other:___________	Email:	
Employer's Name:		Work Phone #:		
Pharmacy Name, Address, and Telephone #:				
Referring Physician's Name and Telephone #:		Primary Care Physician's Name and Telephone #:		

INSURANCE INFORMATION		
Primary Insurance Company Name:		
Identification or Policy Number:	Group Number:	Insurance Company Phone #:
Name of Policyholder:	Patient's Relationship to Policyholder: ❑ Self ❑ Spouse ❑ Partner ❑ Dependent ❑ Other	
Policyholder's Date of Birth:	Policyholder's Sex: ❑ Male ❑ Female	Effective Dates of Insurance:
Secondary Insurance Company Name:		
Identification Number:	Group Number:	Insurance Company Phone #:
Name of Policyholder:	Patient's Relationship to Policyholder: ❑ Self ❑ Spouse ❑ Partner ❑ Dependent ❑ Other	
Policyholder's Date of Birth:	Policyholder's Sex: ❑ Male ❑ Female	Effective Dates of Insurance:

EMERGENCY CONTACT/PARENT OR GUARDIAN OF PATIENT		
Name:	Relationship To Patient: ❑ Spouse ❑ Partner ❑ Parent/Guardian ❑ Child ❑ Other	
Home Phone #:	Work Phone #:	Cell Phone #:

AUTHORIZATION AND RELEASE

* I authorize any holder of medical information about me to release this information to the Health Care Financing Administration, my insurance company or its intermediaries or carriers, or to this physician's office.

* I authorize direct payment of medical benefits and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicare supplemental carrier, private insurance, and any other health plan to Bryn Mawr Medical Specialists Association. I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

* I understand that I am financially responsible for all charges whether or not paid by said insurance.

PATIENT/GUARDIAN SIGNATURE ____ DATE_______________

Please hand this form and your insurance cards to the Receptionist.

REV 6/16

CARDIOLOGY
Francis P. Day, M.D.
John P. Fisher, M.D.
Leslie H. Poor, M.D.
Sean C. Curran, M.D.
Sheetal Chandhok, M.D.
Tarun Mathur, M.D.
Laura S. Immordino, M.D.
(610) 525-1202
Glenn R. Harper, M.D.
John C. Steers, Jr., M.D.
Lawrence S. Mendelson, M.D.
Howard B. Kramer, M.D.
Sarang S. Mangalmurti, M.D.
(610) 527-1165
Jason T. Bradley, M.D.
Jeffrey A. Wuhl, M.D.
(484) 380-2808

DERMATOLOGY
Rochelle R. Weiss, M.D.
Daniel B. Roling, M.D.
Danielle M. DeHoratius, M.D.
Matthew E. Halpern, M.D.
Caroline M. MacFarlane, M.D.
Michael D. Gober, M.D.
(610) 642-1090

ENDOCRINOLOGY
Cheryl A. Koch, M.D.
Vanita P. Treat, M.D.
Denise Joffe, M.D.
Margaret T. Ryan, M.D.
(610) 527-1604

GASTROENTEROLOGY
Robert R. Atkins, M.D.
Jack A. Collazzo, M.D.
Jeffrey N. Retig, M.D.
Robert E. Levitt, M.D.
Tom T. Nguyen, M.D.
Thomas J. McKenna, M.D.
Michelle C. Springer, D.O.
(610) 525-9570

HEMATOLOGY-ONCOLOGY
Sandra F. Schnall, M.D.
John G. Devlin, M.D.
Sameer Gupta, M.D., MPH
Amy L. Curran, M.D.
(610) 525-4511

INFECTIOUS DISEASE
Peter G. Spitzer, M.D.
Bartholomew R. Bono, M.D.
Luciano Kapelusznik, M.D.
Young S. Kim, M.D.
(610) 527-8118

NEUROLOGY
Richard A. Eisner, M.D.
Christopher J. Reid, M.D.
George J. Hart, M.D.
Pragati Shukla, M.D.
Laurence D. Fine, M.D.
(610) 527-8140

PULMONARY/CRITICAL CARE
Andrew P. Pitman, M.D.
David S. Prince, M.D.
Clarke U. Piatt, M.D.
Joseph M. Abboud, M.D.
Catherine A. Riley, M.D.
(610) 527-4896

RHEUMATOLOGY
Donald S. Miller, M.D.
Kendra K. Zuckerman, M.D.
Pierre Minerva, M.D.
Stephanie D. Flagg, M.D., Ph.D.
Liliane Min, M.D.
Sara D. Wasserman, M.D.
(610) 525-4463

BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION
825 OLD LANCASTER ROAD
SUITE 320
BRYN MAWR, PENNSYLVANIA 19010

Financial Policy

We would like to take this opportunity to welcome you to our offices and assure you that we will do our utmost to provide you with the best possible care.

Patients with Insurance Coverage

We will be glad to help you obtain the appropriate benefit from your insurance carrier. It is your responsibility to read and understand your insurance agreement; certain services may or may not be covered, depending on your individual policy. **Please provide current insurance information to the office, including any changes in coverage.** If your insurance requires a form, please provide one to the office. We will bill your insurance carrier as a courtesy to you. **However, you are ultimately responsible for the payment of the bill.**

Portions of the bill may not be paid by the insurance company, and are to be paid by the patient. For example, a co-payment may be required by you as per your insurance agreement. If you are having treatment over a period of time, we appreciate payment during the course of treatment. Our Business Office will gladly assist you in arranging a payment plan. If you are unable or unwilling to accept responsibility for your account balance, please be advised that your account may be forwarded to a collection agency, which will adversely affect your credit.

If you have a **High Deductible Health Plan (HDHP)**, please notify the office prior to your visit. If you have not met your deductible, we will bill you directly for any balance due. Please note, the office may request payment up front.

If you are covered through an **out-of-state insurance plan**, it is your responsibility to contact your carrier and determine if our physicians participate with your plan. Please note that these types of plans typically carry high out-of-pocket expenses.

Patients without Insurance Coverage

Patients without insurance coverage are requested to pay for services as rendered. We accept MasterCard and Visa payments.

I have read and understand the Financial Policy of Bryn Mawr Medical Specialists Association.

X______________________________ ______________
Signature of Patient or Guardian **Date**

Revised: September 22,2017

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE & CONSENT TO USE HEALTH INFORMATION

Read before signing the Acknowledgement & Consent

This acknowledgement of notice and consent authorizes Bryn Mawr Medical Specialists Association to use health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices (revised 8/2013): Bryn Mawr Medical Specialists Association has a Notice of Privacy Practices which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. Please review our current notice prior to signing this acknowledgement and consent.

http://bmmsa.com/wp-content/uploads/2013/07/bmmsa-noticeofprivacy.pdf

If you would like to receive an additional copy of the Privacy Notice, please request one at the time of your appointment.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail: Bryn Mawr Medical Specialists Association
825 Old Lancaster Road, Suite 320
Bryn Mawr, PA 19010
Attention: Russ Militello

Telephone: (610) 527-3800, ext. 3027

Acknowledgement & Consent

I have received the Notice of Privacy Practices for Bryn Mawr Medical Specialists Association. Bryn Mawr Medical Specialists Association is authorized to use health information about (print name) ______________________________ for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

____

Signature of Patient　　　　　　Date　　　　　　Acct#

Personal representative information (if applicable):

____

Name of Personal Representative　　　　　　Relationship to Patient

Please provide us with your contact information and the name or other specific identification of the person(s) or class of persons to whom the covered entity may disclose the covered information:

______ I prefer to be contacted by my physician/physician's office at the following phone number(s) (Please circle the best daytime phone number)

Home: _________________　Cell: ____________________　Other: ___________________

Do we have permission to leave a message?　☐ Yes　☐ No

______ You have permission to speak with the designated/authorized person(s) named:

____

______ You have permission to contact me via e-mail at the following e-mail address:

____ Rev. 2/2016

Bryn Mawr Medical Specialists Association (BMMSA)

Patient Information
(Please print)

Patient name: ___________________________________
Date of Birth: ____/____/________
SSN: ______-______-________

Patient Address: _______________________________________
City: ____
State: ___________________ Zip Code: ___________________

Requestor / Recipient Information

I hereby authorize (complete name and address of facility you wish to have your records release from):
____
____
____
____
____

Please disclose the following protected health information to:
Lisa A. Kenis, DO
6 Lancaster Avenue, Upper Level
Wynnewood, PA 19096
Phone: 484-416-3880 Fax: 484-416-3855

_X_ COMPLETE CHART (ON A CD)
__ Discharge Summary
__ History and Physical
__ Progress Notes
__Operative Notes
__ Pathology Reports
__ Radiology Reports
__ Laboratory Results
__ ECG / EEG / Cardiac Cath
__ Emergency
__ Other:
____

___ I do
___ I do not

Authorize release of information related to AIDS (Acquired Immunodificiency Syndrome) or HIV (Human Immunodificiency Virus) infection, psychiatric care and/or pschologic assessment, and treatment for alcohol and/or drug abuse.

Purpose of disclosure
_X__ Transfer of care
___ Referral to specialist
___ Insurance / Legal investigation
___ Disability Determination
___ Workers Comp
___ Personal

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to Russ Militello, Privacy Officer. I understand that the revocation does not apply to information already released in response to this authorization.

Unless otherwise revoked, this authorization will expire six months from the date it was originally signed or on the following date:
____

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the Privacy Office and request a copy of this authorization.

____ ____
Signature of Patient or Authorized Representative | Date

____ ____
Description of Representatives Authority | Signature of Witness

Name: ______________________________

DOB: ______________________________

Lisa A. Kenis, DO
6 Lancaster Avenue, Upper Level
Wynnewood, PA 19096

Adult Health Assessment Sheet

In order to help us deliver quality care, we would appreciate your responses to the personal history questions below. Please be assured that all responses are kept confidential. You should feel free to discuss any questions you have concerning these items with the doctor.

Do you have any particular health concerns at this time that you would like to discuss with the doctor?

____

____

____

Reoccurring Symptoms:

Please check if you have any of these diseases or if you have any of these reoccurring symptoms.

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Chest Pain / Palpitations
- ☐ Heart Murmur
- ☐ Shortness of Breath
- ☐ Swollen Ankles
- ☐ Palpitations / Heart Pounding
- ☐ Lightheadedness
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Persistent Cough
- ☐ Hay Fever
- ☐ Sinus Problems
- ☐ Abdominal Discomfort
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Change in Bowel Habits
- ☐ Blood in Stool
- ☐ Hemorrhoids
- ☐ Unexplained Weight Loss / Gain
- ☐ Colitis
- ☐ Gall Bladder Disease
- ☐ Pancreatitis
- ☐ Liver Disease
- ☐ Hepatitis / Yellow Jaundice
- ☐ Thyroid Disease
- ☐ Head or Neck Radiation
- ☐ Headache
- ☐ Migraines
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Difficulty Urinating
- ☐ Frequent Urination
- ☐ Arthritis
- ☐ Low Back Problems
- ☐ Bone / Joint Problem
- ☐ Blood Transfusions
- ☐ Lumps / Moles
- ☐ Skin Diseases
- ☐ Sexually Transmitted Diseases
- ☐ HIV / AIDS
- ☐ Anxiety
- ☐ Depression
- ☐ Sleeping Problems
- ☐ Alcohol Abuse
- ☐ Drug Abuse
- ☐ Gout
- ☐ Seizures
- ☐ Visual Problems
- ☐ Hearing Problems
- ☐ Measles
- ☐ Chicken Pox
- ☐ Mumps
- ☐ ________________________
- ☐ ________________________
- ☐ ________________________

Allergies:

Do you have any known allergies to medications, foods, or other substances? If yes, please list along with the reaction that you have.

____

____

____

Medications:

Please list all medications including the doses and instructions that you are currently taking. This includes Prescription, Over the Counter, Insulin, Inhalers, Vitamins, and Herbs.

____

____

____

Hospitalizations and Operations:
Please list all hospitalizations and operations that you have had and give the approximate date of each.

____
____
____

Family History

Is your mother alive? NO ☐ YES ☐ If no, age and cause of death: _____
____

Is your father alive? NO ☐ YES ☐ If no, age and cause of death: _____
____

Number of siblings: Sister(s)______ Brother(s)______

Do any of your siblings have a serious illness? NO ☐ YES ☐ If yes, explain: _________________
____

Have any of your **IMMEDIATE** family members had any of the following illnesses?

Illness	Which family member	Age when diagnosed	Illness	Which family member	Age when diagnosed
Cancer (describe type)			Bleeding Disorders		
High Blood Pressure			Diabetes		
Heart Disease			Asthma		
Strokes			Epilepsy		
Mental Disease			Genetic Disease		
Glaucoma			Arthritis		
Drug/Alcohol Addiction			Kidney Problems		
Other:			Other:		

Immunizations:
Have you have any of the following immunizations?

Hepatitis B NO ☐ YES ☐ Approximate Date _______________
Tetanus NO ☐ YES ☐ Approximate Date _______________
Flu Shot NO ☐ YES ☐ Approximate Date _______________
Pneumovax NO ☐ YES ☐ Approximate Date _______________
Measles NO ☐ YES ☐ Approximate Date _______________
Mumps NO ☐ YES ☐ Approximate Date _______________
Rubella NO ☐ YES ☐ Approximate Date _______________

Advanced Directives:
Do you have a living will? NO ☐ YES ☐
Are you an organ donor? NO ☐ YES ☐

For WOMEN only:

Date of last menstrual cycle? ____________ Age of onset of periods?________________________

Do you do self breast exams monthly? NO ☐ YES ☐

Any histo NO ☐ YES ☐

Any prolonged or abnormal bleeding? NO ☐ YES ☐

Any pelvic pain? NO ☐ YES ☐

Any abnormal discharge? NO ☐ YES ☐

Do you take a calcium supplement? NO ☐ YES ☐

Number of pregnancies __________________ Number of miscarriages or abortions _______________

For MEN only:

Do you do self testicular exams? NO ☐ YES ☐

Have you had a prostate exam? NO ☐ YES ☐

Have you had a PSA (labs to check your prostate NO ☐ YES ☐ If yes, explain: __________________

____

Have you have any problems with urinations? NO ☐ YES ☐ If yes, explain: __________________

____

Sexual History:

Are you sexually active? NO ☐ YES ☐

Would you characterize your sexual preference a ☐Heterosexual ☐Homosexual ☐Bisexual

Do you have multiple sexual partners? NO ☐ YES ☐

Do you use condoms? NO ☐ YES ☐

What method of contraception do you use? ____

Health Maintenance:

When was your last: (give approximate date)

PAP Smear? ____________________ Cholesterol Check? _________________

Breast Exam? ___________________ Stool check for blood? ______________

Mammogram? ___________________ Prostate Exam? ____________________

Complete Physical? ______________ Sigmoid Exam? ____________________

Social History:

How many people live with you now? ____

Present Occupation? ____

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ____________________

Have you ever been exposed to any environmental hazards such as radiation, toxic waste, or lead paint? _____

Personal Habits:

Do you wear your seatbelt? NO ☐ YES ☐

Do you wear a bike helmet? NO ☐ YES ☐ N/A ☐

Do you use tobacco products? NO ☐ YES ☐ If yes, what kind?_________ How much? __________

Do you drink alcohol? NO ☐ YES ☐ If yes, how many drinks per week? _______________

coffee? NO ☐ YES ☐ If yes, how many cups per day? __________________

tea? NO ☐ YES ☐ If yes, how many cups per day? __________________

Do you follow a particular diet? NO ☐ YES ☐ If yes, what type? ______________________________

Do you exercise regularly? NO ☐ YES ☐ If yes, what type? ______________________________

Any recent travel outside the US? NO ☐ YES ☐ If yes, where? _________________________________

Do you have a gun in your home? NO ☐ YES ☐ If yes, is it under lock and key? __________________

Do you use drugs? NO ☐ YES ☐

Do you have smoke detectors in your hon NO ☐ YES ☐