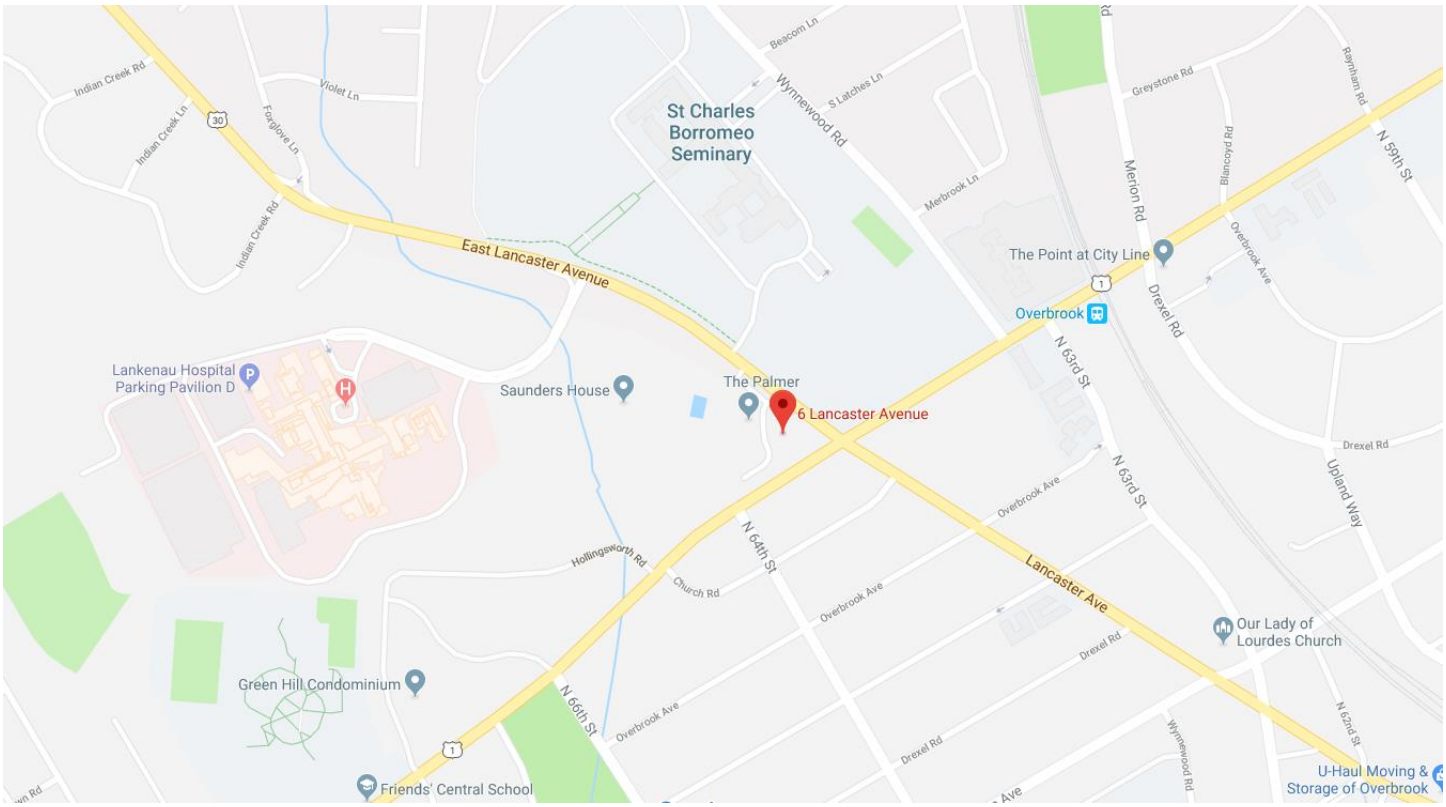
New Patient Reminder

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: _____ Patient Address: _____
Date of Birth: ____/____/_____ City: _____
SSN: _____-_____-_____ 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)	__Operative Notes	__ ECG / EEG / Cardiac Cath
__ Discharge Summary	__ Pathology Reports	__ Emergency
__ History and Physical	__ Radiology Reports	__ Other:
__ Progress Notes	__ Laboratory Results	_____

___ 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 pyschologic assessment, and treatment for alcohol and/or drug abuse.

Purpose of disclosure

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

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

Name: _____

DOB: _____

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 ☐