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:

_____

Bryn Mawr Medical Specialists Association
Cardiology
Bryn Mawr Medical Arts Pavilion
825 Old Lancaster Road
Bryn Mawr, PA, 19010

PATIENT INFORMATION

Name: _____

Date of Birth: _____

Today's Date: _____

Reason for visit: _____

Allergies: _____

MEDICATIONS

Did You Bring A Medications List? ☐ Yes ☐ No

	Drug Name:	Dose:	Frequency:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

PAST MEDICAL HISTORY

Cardiovascular:	High blood pressure	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
	Myocardial Infarction	☐ Yes	☐ No	Coronary Artery Disease	☐ Yes	☐ No
	Congestive heart failure	☐ Yes	☐ No	If yes, date:_____		
	Cardiomyopathy	☐ Yes	☐ No	If yes, date:_____		
	Valvular heart disease	☐ Yes	☐ No	If yes, date:_____		
	Abnormal heart rhythm	☐ Yes	☐ No	If yes, date:_____		
	Ablation	☐ Yes	☐ No	If yes, date:_____		
	Pacemaker	☐ Yes	☐ No	If yes, date:_____		

Past Medical History (continued)

CARDIOVASCULAR:	Defibrillator	☐ Yes	☐ No	If yes, date:_____
	Echocardiogram (Echo)	☐ Yes	☐ No	If yes, date:_____
	Stress Test	☐ Yes	☐ No	If yes, date:_____
	Cardiac Catheterization	☐ Yes	☐ No	If yes, date:_____
	Cardiac Stent	☐ Yes	☐ No	If yes, date:_____
	Bypass surgery	☐ Yes	☐ No	If yes, date:_____
	Valve replacement surgery	☐ Yes	☐ No	If yes, date:_____
	Peripheral Vascular Disease	☐ Yes	☐ No	If yes, date:_____
	Varicose Veins	☐ Yes	☐ No	If yes, date:_____
	Chronic Venous Insufficiency	☐ Yes	☐ No	If yes, date:_____
	Surgery performed?	☐ Yes	☐ No	If yes, date:_____
	Carotid Artery Disease	☐ Yes	☐ No	If yes, date:_____
	Surgery performed?	☐ Yes	☐ No	If yes, date:_____
	Aneurysm	☐ Yes	☐ No	If yes, date:_____
	Surgery Performed?	☐ Yes	☐ No	If yes, date:_____

NEUROLOGY: ☐ Stroke/TIA ☐Seizures ☐Neuropathy

ENDOCRINE: ☐Diabetes ☐Thyroid Disorder

PULMONARY: ☐Asthma ☐COPD ☐Sleep Apnea ☐Pulmonary Embolism

GASTROINTESTINAL: ☐Ulcers ☐ GERD ☐Hiatal hernia ☐Liver Disease ☐Gallbladder Disease

KIDNEY DISEASE: ☐ Yes ☐No If yes, please state: _____

OTHER: ☐Prostate disorder ☐Erectile dysfunction ☐Breast Cancer
☐Gynecologic disorder

RHEUMATOLOGIC/MUSCULOSKELETAL DISORDER: ☐Yes ☐No If yes, please state: _____

BLOOD DISORDER/CLOTTING DISORDER/BLOOD CLOTS: ☐Yes ☐No If yes, please state: _____

CANCER HISTORY: ☐Yes ☐No If yes, please state: _____

Other:_____
_____

Surgical History

Procedure:	Date:	Procedure:	Date:
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

Social History

Have you ever smoked? ☐ Yes ☐No If yes, how many per day? _____

If yes, how many years have you smoked? _____

If yes, did you quit? ☐Yes ☐No If yes, when did you quit? _____

Do you drink alcohol? ☐Yes ☐No If yes, about how many drinks per week? _____

Do you use illicit drugs? ☐Yes ☐No If yes, what drugs? _____

What is your occupation? _____

Do you exercise? ☐Yes ☐No If yes, how do you exercise? _____

If yes, how often do you exercise? _____

Family History

	MOTHER	FATHER	SIBLING	CHILDREN
Heart Attack / CAD: (Coronary Artery Disease)	☐	☐	☐	☐
Diabetes:	☐	☐	☐	☐
Sudden Cardiac Death: (Death <50 years old)	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐
High Cholesterol:	☐	☐	☐	☐
Cardiomyopathy:	☐	☐	☐	☐
Aortic Aneurysm/Dissection:	☐	☐	☐	☐
Unexplained sudden death:	☐	☐	☐	☐
Congenital heart disease:	☐	☐	☐	☐
No Significant History:	☐	☐	☐	☐

Review of Symptoms (Check All That Apply)

☐ Fatigue	☐ Fevers	☐ Weight Change	☐Headache	☐Dizziness
☐Visual Problem	☐Hearing Difficulty	☐Sinus Congestion	☐Jaw Pain	☐Neck Pain
☐Chest Pain/discomfort		☐Heartburn	☐Passing out spells	☐Palpations
☐Cough	☐Wheezing	☐Shortness of breath	☐Nausea	☐Vomiting
☐Difficulty Swallowing	☐Frequent Urination	☐Blood in Urine	☐Blood in Stool	☐Diarrhea
☐Abdominal Pain	☐Erectile Dysfunction	☐Muscle Aches	☐Localized Numbness/Weakness	
☐Joint Aches	☐Leg Discomfort	☐Leg Swelling	☐Skin Lesions	☐ Rash

OTHER:_____

_____

DO YOU HAVE ANY PARTICULAR QUESTIONS YOU WANTED ANSWERED TODAY?

_____

_____

Please arrive 15 minutes before your scheduled appointment. Thank you!