David S. Prince, M.D.
Clarke U. Piatt, M.D.
Joseph M. Abboud, M.D.
Catherine A. Riley, M.D.
Michael E. Post, D.O.

Pulmonary, Critical Care and Sleep Medicine
Bryn Mawr Medical Specialists Association
Bryn Mawr Medical Arts Pavilion
825 Old Lancaster Road, Suite 420
Bryn Mawr, PA 19010
610-527-4896

Please complete the enclosed registration and medical history forms and bring them with you on the day of your appointment.

If your insurance company requires a referral for your office visit, please contact your primary care physician.

If you had radiology imaging done outside of the Main Line Hospitals health system, please remember to bring those films and reports with you to your initial visit.

Please provide a minimum of 24 hours notice if you are unable to keep your scheduled appointment. We reserve the right to charge missed appointments for which we have not been notified of prior to 24 hours.

We are looking forward to meeting with you.

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NAME:_____

YOUR AGE: _____ TODAY'S DATE: _____

REFERRING PHYSICIAN'S NAME/ADDRESS:

_____

LIST THE MAIN PROBLEM, SYMPTOMS OR REASONS YOU ARE COMING TO SEE THE DOCTOR:

_____

LIST ANY DRUG ALLERGIES AND SENSITIVITIES:

_____

LIST ALL CURRENT MEDICATIONS, STRENGTH AND FREQUENCY (include inhalers)

_____ _____

_____ _____

_____ _____

_____ _____

LIST PAST/CURRENT MEDICAL CONDITIONS:

_____ _____

_____ _____

LIST PRIOR AND/OR PLANNED SURGERIES :

_____ _____

_____ _____

DO YOU HAVE PROBLEMS WITH COUGH? YES NO

If yes, describe _____

ARE YOU SHORT OF BREATH? YES NO

If yes, describe _____

ARE YOU SHORT OF BREATH AT NIGHT? YES NO

WHAT IS YOUR OCCUPATION? (WHAT HAVE YOU DONE IN THE PAST?)

_____

LIST POTENTIAL WORK OR ENVIRONMENTAL EXPOSURES:

_____

HAVE YOU EVER SMOKED? YES NO

ARE YOU CURRENTLY SMOKING? YES NO
HOW MANY YEARS TOTAL HAVE YOU SMOKED? _____ HOW MANY PACKS/DAY? _____
IF YOU STOPPED, HOW MANY YEARS AGO DID YOU QUIT? _____
IF CURRENTLY SMOKING, HAVE YOU TRIED TO QUIT BEFORE? YES NO

HAVE YOU USED CIGARS OR CHEWING TOBACCO? DESCRIBE _____

DO YOU DRINK ALCOHOL? YES NO
IF YES, CIRCLE ONE: EVERY DAY ONCE/TWICE A WEEK RARELY/SEVERAL TIMES A MONTH

WHO LIVES WITH YOU AT HOME?

_____

TRAVEL HISTORY: LIST ANY SIGNIFICANT TRAVEL WITHIN OR OUTSIDE OF THE UNITED STATES IN THE LAST 5 YEARS

_____

_____

LIST ALL PETS AND ANIMAL EXPOSURES/SENSITIVITES:

_____

FAMILY HISTORY: (CIRCLE ALL THAT APPLY)

LUNG DISEASE	ASTHMA	CANCER	SLEEP APNEA
DEEP VEIN CLOT (DVT)	PULMONARY EMBOLIC	CYSTIC FIBROSIS	STROKE
HEART ATTACK	CONGESTIVE HEART FAILURE	DIABETES	DEPRESSION
HYPERTENSION	OTHER _____		

MOTHER'S AGE ALIVE _____ DECEASED/AGE _____ CAUSE: _____
FATHER'S AGE ALIVE _____ DECEASED/AGE _____ CAUSE: _____

DO YOU SNORE? YES NO

ARE YOU SLEEPY DURING THE DAY? YES NO

DO YOU HAVE INSOMNIA? YES NO
IF YES, DESCRIBE _____

DO YOU HAVE LEG DISCOMFORT ASSOCIATED WITH SLEEP? YES NO

DO YOU KICK IN YOUR SLEEP? YES NO

LIST BEDTIME _____ LIST WAKE TIME _____ AMOUNT OF TIME FOR SLEEP ONSET _____

NUMBER OF WAKING EPISODES AT NIGHT _____

DESCRIBE CAFFEINE USE _____

PAST MEDICAL HISTORY

PULMONARY

ABNORMAL TB TEST
ASTHMA
COPD
COUGH
EMPHYSEMA
LUNG MASS
PNEUMONIA
PULMONARY EMBOLISM
SARCOIDOSIS
SLEEP APNEA
TUBERCULOSIS

CARDIOVASCULAR

ATRIAL FIBRILLATION
ANEMIA
CORONARY ARTERY DISEASE
CARDIOMYOPATHY
CONGESTIVE HEART FAILURE
DVT
HYPERTENSION
HYPERLIPODEMIA
PERIPHERAL VASCULAR DISEASE
TRANSIENT ISCHEMIC ATTACK

HEAD

CATARACT
GLAUCOMA
SINUSITIS
VISUAL DISTRUBANCES

MUSCULOSKELETAL

CONNECTIVE TISSUE DISEASE
OSTEOARTHRITIS
OSTEOPOROSIS
SYSTEMIC LUPUS
RHEUMATOID ARTHRITIS

ENDOCRINE

HYPOTHYROIDISM
HYPERTHYROIDISM
DIABETES 1
DIABETES 2

GASTROINTESTINAL

CHRONIC LIVER DISEASE
COLITIS
CROHN'S DISEASE
DIVERTICULOSIS
ESOPHAGEAL REFLUX
PEPTIC ULCER

GENITOURINARY

BENIGN PROSTATIC HYPERTROPHY
ERECTILE DISORDER
URINARY TRACT INFECTION
RENAL DISORDER

NEUROLOGICAL

ANXIETY DISORDER
DEPRESSION
HEADACHE
MIGRAINE HEADACHE
SEIZURE DISORDER

CANCER

BLADDER
BONE
BRAIN
BREAST
CERVICAL
ESOPHAGEAL
GASTRIC
HODGKIN'S
NON-HODGKIN'S LYMPHOMA
KIDNEY
OTHER _____

LARYNGEAL
LEUKEMIA
LIVER
LUNG
PROSTATE
RECTAL
SKIN
TESTICULAR
THYROID
THYROID
UTERINE

SURGICAL HISTORY

THYROID SURGERY
CATARACT SURGERY
SINUS SURGERY
SHOULDER SURGERY
WRIST SURGERY
HAND SURGERY
HIP SURGERY
KNEE SURGERY

GYNECOLOGICAL

BREAST BIOPSY
MASTECTOMY
C SECTION
HYSTERECTOMY

LUNG

BRONCHOSCOPY
LUNG BIOPSY
LOBECTOMY
LUNG SURGERY

GI/GU

APPENDECTOMY
CHOLYCYSTECTOMY(GALBLADDER)
PROSTATECTOMY
GASTROINTESTINAL SURGERY
BARIATRIC SURGERY

CARDIOVASCULAR

THORACIC ANEURYSM
ABDOMINAL AORTIC ANEURYSM
HEART VALVE REPLACEMENT
PTCA
CABG(CORONARY ARTERY BYPASS)
CAROTID ENDARTERECTOMY
CATHETERIZATION

HEAD AND NECK

TONSILLECTOMY
THROAT SURGERY
NECK SURGERY

DID YOU EVER HAVE PNEUMONIA VACCINE? YES NO

PNEUMOVAX (DATE)_____ PREVNAR (DATE) _____

DO YOU RECEIVE ANNUAL INFLUENZA VACCINE? YES NO

REVIEW OF SYSTEMS:
(CIRCLE ALL THAT APPLY)

GENERAL

WEIGHT LOSS
WEIGHT GAIN
FEVER
CHILLS
NIGHT SWEATS
FEELING TIRED (FATIGUE)
OTHER _____

SLEEP

INSOMNIA
SNORING
GASPING FOR BREATH AT NIGHT
INVOLUNTARY MOVEMENTS DURING SLEEP

GASTROINTESTINAL

NAUSEA
VOMITING
HEARTBURN OR REFLUX
DIARRHEA
CONSTIPATION
SWALLOWING DIFFICULTY
CHOKING ON FOOD
STOMACH PAIN
BLOOD IN STOOL

HEAD AND NECK

SINUSITIS
NASAL CONGESTION
SEASONAL ALLERGIES
NOSE BLEEDS
COUGH
VISION DIFFICULTIES
LOSS OF HEARING
RINGING IN EARS
HOARSENESS

RESPIRATORY

SHORTNESS OF BREATH
SHORTNESS OF BREATH WHEN FLAT IN BED
COUGHING UP BLOOD

CARDIAC

PALPITATIONS
CHEST PAIN
SWELLING IN LEGS/ANKLES
ANGINA

BONE AND JOINTS

JOINT PAIN
MUSCLE PAIN
BACK PAIN

NEUROLOGIC

NUMBNESS
WEAKNESS
HEADACHE
TREMOR
POOR MEMORY

SKIN

RASH
WOUNDS
BRUISE EASILY

MEN

INCONTINENCE (LOSS OF CONTROL OF URINE)
IMPOTENCE
URINARY DIFFICULTY
FREQUENT NIGHTIME URINATION

WOMEN

INCONTINENCE (LOSS OF CONTROL OF URINE)
MENOPAUSE
IRREGULAR MENSTRUAL CYCLE

FOR OFFICE USE ONLY
SYSTEMS REVIEWED IN FULL AND NO OTHER SIGNIFICANT FINDINGS NOTED

_____ _____

ATTENDING DATE

Bryn Mawr Medical Specialists Association					2022 Patient Intake Form
Visit Date:		Provider:			
Patient Information					
Last Name:		First Name:		DOB:	

Vaccination Status			
Have you received an influenza vaccination this Flu season? August 1, 2022 - March 31, 2023	☐ Yes, Date: _____	☐ Declined	☐ Allergies
Patients aged 66 years and older: Have you received pneumococcal vaccination on or after your 60th birthday?	☐ Yes, Date: _____	☐ Allergy or Medical Reason for not receiving:	

Tobacco Status	
Current tobacco user? (any type)	☐ Yes ☐ No
Staff Use Only: If yes, was tobacco cessation intervention or education performed?	☐ Yes ☐ No
Colorectal Cancer Screening: Patients aged 50 to 75 years	
Have you had a Fecal occult blood test (FOBT) this year (2022)?	☐ Yes ☐ No
Have you had a Flexible sigmoidoscopy this year or in the last four years (2018 – 2022)?	☐ Yes ☐ No
Have you had a Colonoscopy this year or in the nine years prior (2013 – 2022)?	☐ Yes ☐ No
Have you had a FIT-DNA this year or in the past two years (2020 - 2022)?	☐ Yes ☐ No
Have you had a CT Colonography this year or in the past four years (2018 – 2022)?	☐ Yes ☐ No
Do you have a history of a total colectomy or colorectal cancer?	☐ Yes ☐ No
Falls: Plan of Care: 65 years and Older	
Have you had a fall or recurrent falls in the past year?	☐ Yes ☐ No
Female Patients aged 21 – 64: Cervical CA Screening	
Have you had a hysterectomy with no residual cervix or a congenital absence of cervix?	☐ Yes ☐ No
Women aged 21-64: Have you had cervical cytology performed within the last 3 years?	☐ Yes ☐ No
Women aged 30-64: Have you had cervical human papillomavirus (HPV) testing performed within the last 5 years?	☐ Yes ☐ No
Female Patients aged 51 – 74: Breast CA Screening	
Have you had a bilateral mastectomy?	☐ Yes ☐ No
Have you had a Mammograms during the last 27 months?	☐ Yes ☐ No
Diabetic Patients Only 18 – 75 years old	
Diabetic Eye Exam: Have you had a diabetic retinal or dilated eye exam by an eye care professional this year 2022?	☐ Yes ☐ No
Staff Use Only: Diabetes: Medical Attention for Nephropathy: Has the patient had a screening for nephropathy or evidence of nephropathy during 2022?	☐ Yes ☐ No If no, send for referral to provider that can complete screening
Staff Use Only: Diabetes HgBA1C poor Control, Goal < 9% ☐ HgbA1C level (must be performed in 2022): _____ If no HgbA1C completed in 2022, was one ordered on date of visit? ☐ Yes ☐ No **Triggers quality analysis to request HgbA1c values at later date*	

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:

_____

CARDIOLOGY
Wayne W. Keller, M.D.
Henry S. Mayer, M.D.
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 Immordino, M.D.
(610) 525-1202
Glenn R. Harper, M.D.
John C. Steers, M.D.
Lawrence S. Mendelson, M.D.
Howard B. Kramer, M.D.
Sarang Mangalmurti, M.D.
(610) 527-1165

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

GASTROENTEROLOGY
Robert R. Atkins, M.D.
Jack A. Collazzo, M.D.
Jeffrey N. Relig, M.D.
Tom T. Nguyen, M.D.
Thomas J. McKenna, M.D.
(610) 525-9570
Robert E. Levitt, M.D.
(610) 525-0655

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

INFECTIOUS DISEASE
Peter G. Spitzer, M.D.
Hans H. Liu, M.D.
Bartholomew R. Bono, M.D.
(610) 527-8118
Young S. Kim, M.D.
(610) 560-0014

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

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.
(610) 525-4463

PULMONARY/CRITICAL CARE
Edward A. Theurkauf, Jr., M.D.
(610) 525-0200
Andrew P. Pitman, M.D.
David S. Prince, M.D.
Clarke U. Piatt, M.D.
Joseph M. Abboud, M.D.
Siva Ramachandran, M.D.
(610) 527-1896

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

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: March 8, 2013

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 (M) ❑ Female (F) Gender Identity: ❑ Transgender Male (FTM) ❑ Transgender Female (MTF) ❑ Genderqueer (G) ❑ Other (O)
Patient's Street Address:			Marital Status: ❑ S ❑ M ❑ D ❑ W	
City:	State, ZIP: (9 digit if known)	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 #:	Cell Phone #:	Work Phone #:

AUTHORIZATION AND RELEASE

* I authorize any holder of medical information about me to release this information to the Centers for Medicare and Medicaid Services, 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 12/21