Bryn Mawr Medical Specialists ASSOCIATION

ENDOCRINOLOGY DIVISION

825 OLD LANCASTER ROAD SUITE 360
BRYN MAWR, PA 19010
610-527-1604

Date of Appointment _____ Time of Appointment_____

Dear New Patient:

We welcome you to our practice and look forward to meeting you at your appointment.

To make your check in process as simple as possible, we ask that you complete the enclosed forms **PRIOR** to your appointment. **PLEASE BRING THESE COMPLETED FORMS WITH YOU TO YOUR APPOINTMENT, along with your INSURANCE CARD, PHOTO ID, & REFERRAL IF YOUR INSURANCE REQUIRES ONE**. You will need approximately 15 minutes at our front desk to register.

It is also **extremely** important that you bring any blood work or radiology studies you have had done relevant to your Endocrine appointment. Please do not rely on your doctor's office to forward this information. This is your responsibility. *** Please note, we are NOT part of Main Line Health's **"MY CHART SYSTEM"**

We ask that diabetic patients using a glucose meter bring the meter with them to their appointment.

Additionally, if you have an HMO insurance and require a referral, you must obtain one from your PCP before coming in for your appointment. By not doing this, it could result in needing to reschedule your appointment.

Information your Primary Care Physician will need to generate referral

NPI: 1841226099 (Multispecialty Group) **Diagnosis Code**: Z00.00

Procedure: Evaluate & Treat **Date of Service**: Date you are being seen or before

We look forward meeting you.

BRYN MAWR MEDICAL SPECIALISTS' ASSOCIATION

ENDOCRINOLOGY DEPARTMENT

Cheryl Koch, M *Denise Joffe, MD* *Vanita Treat, MD* *Rachel Abramczyk, DO*

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PATIENT MEDICAL HISTORY FORM

Patient Name _____ **Date of Birth**:_____

REASON FOR TODAYS VISIT

CURRENT MEDICAL CONDITIONS/SURGERIES/HOSPITALIZATIONS – *Please list below*

MEDICATIONS YOU CURRENTLY TAKE (Please use attached list to complete) (Please include any vitamins you take)

ALLERGIES - *Please list below*

FAMILY HISTORY	**LIVING/DECEASED**	**AGE**	**ILLNESS**
FATHER:			
MOTHER:			
SISTER:			
BROTHER:			
M-GRANDPARENT			
P- GRANDPARENT			

Does anyone in your family have the following … If so please indicate whom

ANEMIA	YES/NO	WHO:
DIABETES	YES/NO	WHO:
HIGH BLOOD PRESSURE	YES/NO	WHO:
NEUROLOGIC DISORDER	YES/NO	WHO:
THYROID DISORDER	YES/NO	WHO:

SOCIAL HISTORY

CIGARETTES:

CURRENT FORMER NEVER

How many packs per day

How long have you smoked

When did you quit

ALCOHOL YES/NO

How many drinks per week

VITAMINS YES/NO **Please list on medication list**

EXERCISE YES/NO

MARITAL STATUS (***please circle***) M S D W

WOMEN ONLY

Number of successful pregnancies

Miscarriages Y N How Many?

Last GYN exam?

MEN ONLY

Erectile Dysfunction YES NO

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CURRENT MEDICATION LIST

MEDICATION	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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PRESCRIPTION RENEWAL POLICY

ENDOCRINE DEPARTMENT

Dear Patient:

In order to ensure you are always receiving the best possible care, your doctor will recommend at what interval(s) you need to follow up with her. How often the doctor requests you to follow up will depend on your diagnosis, current status with that diagnosis, etc. (such as diabetics who are normally requested to follow up every 3-4 months) However, you should be advised of the following information.

-You **MUST** be seen by your physician at least once every 12 months unless you make specific arrangements with your doctor otherwise.

If you do not follow up with your doctor within 12 months of your last appointment, we will be unable to refill any prescriptions for you until you are seen.

Making sure you are seen minimally every 12 months (unless your doctor directs you otherwise) ensures that the best medication and best dosage of it are prescribed for you.

We ask you please sign below, stating you understand our "***Prescription Refill Policy***":

_____ _____

PATIENT NAME **DATE**

_____

DATE OF BIRTH

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To best serve our patients, we have enforced the following protocol.

MISSED APPOINTMENTS for NEW PATIENTS & ESTABLISHED PATIENTS

New Patient appointments are in such high demand that we have been forced to institute the following protocol.

If you are unable to keep your scheduled appointment, please call our office at least **48 hours** prior to your appointment to cancel or reschedule. ***If you fail to do this, you will be charged a $75.00 NO SHOW FEE***. Missing more than 2 scheduled appointments may result in a dismissal from our practice.

LATE APPOINTMENTS FOR NEW & ESTABLISHED PATIENTS

Because it takes time to register and update patient information, we ask that you arrive to your appointment at least 10-15 minutes **BEFORE** your scheduled time.

If you arrive 15 minutes PAST your appointment time you may be asked to reschedule.

This goes for ALL patients, new and established.

Thank you for your cooperation and understanding.

Cheryl Koch, MD

Denise Joffe, MD

Vanita Treat, MD

Rachel Abramczyk, DO

By signing below, you have read and understood our office protocol

NAME _____ DATE _____

Bryn Mawr Medical Specialists Association					2024 Patient Intake Form
Visit Date:		Provider:			
Last Name:		First Name:		DOB:	

Have you received an influenza vaccination this current Flu season? **August 1, 2023 - March 31, 2024**	Date: _____	☐ Declined	☐ Allergy
Patients aged 60 years and older: Have you received pneumococcal vaccination on or after your 60th birthday?	Date: _____	☐ Declined	☐ Allergy
When was your last visit with your Primary Care Physician	Date:_____	Upcoming: Y/N	Date:

Current tobacco user? (any type)	☐ Yes ☐ No

Depression Screening – All patients	
Little interest or pleasure in doing things?	☐ Not at all ☐ Several Days ☐ More than half the days ☐ Every Day
Feeling down, depressed, or hopeless?	☐ Not at all ☐ Several Days ☐ More than half the days ☐ Every Day
Trouble falling or staying asleep or sleeping too much?	☐ Not at all ☐ Several Days ☐ More than half the days ☐ Every Day
Feeling tired or having little energy?	☐ Not at all ☐ Several Days ☐ More than half the days ☐ Every Day
Poor appetite or overeating?	☐ Not at all ☐ Several Days ☐ More than half the days ☐ Every Day
Feeling bad about yourself or that you are a failure or have let yourself or family down?	☐ Not at all ☐ Several Days ☐ More than half the days ☐ Every Day
Trouble concentrating on things such as reading newspaper or watching television?	☐ Not at all ☐ Several Days ☐ More than half the days ☐ Every Day
Wishing to be dead or of hurting yourself?	☐ Not at all ☐ Several Days ☐ More than half the days ☐ Every Day

Colorectal Cancer Screening: Patients aged 45 to 75 years - Choose ONE	
Do you have a history of a total colectomy or colorectal cancer?	☐ Yes ☐ No
Have you had a Fecal occult blood test (FOBT) this year?	☐ Yes ☐ No
Have you had a Flexible sigmoidoscopy this year or in the last five years?	☐ Yes ☐ No
Have you had a Colonoscopy in the past 10 years?	☐ Yes ☐ No
Have you had a Cologuard or FIT-DNA this year or in the past three years?	☐ Yes ☐ No

Falls: Plan of Care: 65 years and Older	
Have you had a fall or recurrent falls in the past year?	☐ Yes ☐ No
Any injury related fall in 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 35 – 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? Date_____**	☐ Yes ☐ No