

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: <input type="checkbox"/> Male (M) <input type="checkbox"/> Female (F) Gender Identity: <input type="checkbox"/> Transgender Male (FTM) <input type="checkbox"/> Transgender Female (MTF) <input type="checkbox"/> Genderqueer (G) <input type="checkbox"/> Other (O) |
| Patient's Street Address: | | | Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W | |
| City: | State, ZIP: <small>(9 digit if known)</small> | Patient's Home Phone #: | Patient's Cell Phone #: | |
| <u>Billing</u> Street Address of Responsible Party (if different from above): | | | Race: <input type="checkbox"/> African-American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Other Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic | |
| City: | State, ZIP: | Primary Language: <input type="checkbox"/> English <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Dependent <input type="checkbox"/> Other | |
| Policyholder's Date of Birth: | Policyholder's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | Effective Dates of Insurance: |
| Secondary Insurance Company Name: | | |
| Identification Number: | Group Number: | Insurance Company Phone #: |
| Name of Policyholder: | Patient's Relationship to Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Dependent <input type="checkbox"/> Other | |
| Policyholder's Date of Birth: | Policyholder's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | Effective Dates of Insurance: |

| EMERGENCY CONTACT/PARENT OR GUARDIAN OF PATIENT | | |
|---|---|---------------|
| Name: | Relationship To Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Child <input type="checkbox"/> 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 ("BMMSA"). I further agree to allow BMMSA to file an appeal on my behalf with my health plan. 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.



825 OLD LANCASTER ROAD SUITE 320
BRYN MAWR, PA 19010
610-527-3800

Consent To Treatment / Venue Selection Form

Consent to Medical Care

I hereby present myself for medical care at Bryn Mawr Medical Specialists Association (“BMMSA”) and voluntarily consent to receive medical care including evaluation and management, routine diagnostic testing, medical procedures and other treatment by authorized agents/employees of BMMSA.

I acknowledge that no guarantees have been made to me regarding the results of the treatment rendered by BMMSA. As a patient, I understand that I will have access to current and complete information about my condition and will, unless otherwise specified, receive continuity of treatment and receive medical care according to a properly sequenced plan of treatment by one of BMMSA’s physicians and/or advance practice providers (APPs).

I acknowledge that before receiving any treatment, I will have an opportunity to ask any questions I may have to the physician and/or APP before I decide whether to give consent for the procedure(s) to be performed and/or treatment rendered. I further acknowledge that all medical procedures and treatment may involve risks, including the risk of an unsuccessful result and/or complications, and that no guarantee has been made as to a result or cure. I have the right, at all times, to be informed of any such risks, as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of not agreeing to the treatment plan. I have the right to consent to or refuse any proposed procedure and/or treatment at any time prior to its performance.

Venue Selection Agreement

NOTICE: In consideration for all current and future medical treatment provided by BMMSA, any legal claims or civil actions, including, but not limited to, a claim for medical malpractice in any way related to the evaluation, procedures, treatment and all following medical services provided by BMMSA or its agents/employees, shall be brought solely in the courts of the county in which care is provided, in the Commonwealth of Pennsylvania.

If you do **not** agree with the above, you must **initial here** _____ or you will be bound by the above.
Initials

Patient Name (print): _____ **Patient Date of Birth:** _____

Patient Signature: _____ **Date signed:** _____

FOR BMMSA USE ONLY

Patient Account Number: _____

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

Read before signing the Acknowledgement and 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 only.

Notice of Privacy Practices (last revised 3/2026): 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.

<https://bmmsa.com/wp-content/themes/bmmsa/assets/pdf/bmmsa-hippa-notice-of-privacy-practices.pdf>

If you would like to receive a paper 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.

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

Phone: (610) 527-3800, extension 4177

Acknowledgement & Consent

I have received the notice of Privacy Practices for Bryn Mawr Medical Specialists Association. Bryn Mawr Medical Specialist Association is authorized to use health information regarding _____
(**Print Name**) for treatment, payment, and healthcare operation purposes consistent with its Notice of Privacy Practices.

Signature of Patient or Representative Date of Birth Date Account #

Relationship to Patient (if applicable): _____

Release of Covered Information

Please **CIRCLE** your preferred phone number

Home: _____ Office may leave **message with detailed information.**

Mobile: _____ Office may leave **message with callback number/name only.**

Email Address: _____

I give permission to disclose personal health information to the following person(s):

| Name | Relationship (spouse, parents, adult children, siblings, personal representative, etc.) | Phone Number |
|------|---|--------------|
| | | |
| | | |
| | | |

| Bryn Mawr Medical Specialists Association | | | 2026 Patient Intake Form | | |
|--|--|--|------------------------------------|--|--|
| Visit Date: | | Provider: | | | |
| Last Name: | | First Name: | | DOB: | |
| Last PCP Visit: | | PCP Name: | | PCP Phone Number: | |
| Tobacco Status – All Patients | | | | | |
| Are you a current tobacco user? <input type="radio"/> Yes <input type="radio"/> No | | | | | |
| Colorectal Cancer Screening: Patients aged 45 to 75 years - Choose ONE | | | | | |
| Do you have a history of a total colectomy or colorectal cancer? | | | | | <input type="radio"/> Yes <input type="radio"/> No |
| Have you had a Fecal occult blood test (FOBT) this year? | | | Date: _____ | <input type="radio"/> Yes <input type="radio"/> No | |
| Have you had a Flexible sigmoidoscopy this year or in the last five years? | | | Date: _____ | <input type="radio"/> Yes <input type="radio"/> No | |
| Have you had a Colonoscopy in the past 10 years? | | | Date: _____ | <input type="radio"/> Yes <input type="radio"/> No | |
| Have you had a Cologuard or FIT-DNA this year or in the past three years? | | | Date: _____ | <input type="radio"/> Yes <input type="radio"/> No | |
| Female Patients aged 50 – 74: Breast CA Screening | | | | | |
| Have you had a bilateral mastectomy? | | | | | <input type="radio"/> Yes <input type="radio"/> No |
| Have you had a Mammograms during the last 27 months? (10/1/2024-12/31/2026) | | | Date: _____ | <input type="radio"/> Yes <input type="radio"/> No | |
| Depression Screening part 1 – All patients (If you answer yes to any of these questions, please complete part 2) | | | | | |
| Depression: Little interest or pleasure in doing things? | | | | | <input type="radio"/> Yes <input type="radio"/> No |
| Depression: Feeling down, depressed, or hopeless? | | | | | <input type="radio"/> Yes <input type="radio"/> No |
| Depression Screening part 2 – All patients pt (If you answered yes to any questions in part 1, please answer the questions below) | | | | | |
| Little interest or pleasure in doing things? | | <input type="radio"/> Not at all <input type="radio"/> Several Days <input type="radio"/> More than half the days <input type="radio"/> Every Day | | | |
| Feeling down, depressed, or hopeless? | | <input type="radio"/> Not at all <input type="radio"/> Several Days <input type="radio"/> More than half the days <input type="radio"/> Every Day | | | |
| Trouble falling or staying asleep or sleeping too much? | | <input type="radio"/> Not at all <input type="radio"/> Several Days <input type="radio"/> More than half the days <input type="radio"/> Every Day | | | |
| Feeling tired or having little energy? | | <input type="radio"/> Not at all <input type="radio"/> Several Days <input type="radio"/> More than half the days <input type="radio"/> Every Day | | | |
| Poor appetite or overeating? | | <input type="radio"/> Not at all <input type="radio"/> Several Days <input type="radio"/> More than half the days <input type="radio"/> Every Day | | | |
| Feeling bad about yourself or that you are a failure or have let yourself or family down? | | <input type="radio"/> Not at all <input type="radio"/> Several Days <input type="radio"/> More than half the days <input type="radio"/> Every Day | | | |
| Trouble concentrating on things such as reading newspaper or watching television? | | <input type="radio"/> Not at all <input type="radio"/> Several Days <input type="radio"/> More than half the days <input type="radio"/> Every Day | | | |
| Moving or speaking slowly or being fidgety or restless | | <input type="radio"/> Not at all <input type="radio"/> Several Days <input type="radio"/> More than half the days <input type="radio"/> Every Day | | | |
| Wishing to be dead or hurting yourself? | | <input type="radio"/> Not at all <input type="radio"/> Several Days <input type="radio"/> More than half the days <input type="radio"/> Every Day | | | |
| Activities of daily living due to the depression symptoms are: | | <input type="radio"/> Not difficult at all <input type="radio"/> Somewhat difficult <input type="radio"/> Very difficult <input type="radio"/> Extremely difficult | | | |
| Staff Use Only: Diabetes HgBA1C poor Control, Goal < 9% <input type="radio"/> HgbA1C level (must be performed in 2026): _____ | | | | | |
| ENTER IN LABS IN EMR | | | | | |
| HTN All patients diagnosed with hypertension: Goal BP < 140/90 | | | Blood Pressure: _____ Enter in EMR | | |