MFM NEW PATIENT FORMS

TELL US ABOUT YOU ☺ ☻

Patient Information:

Legal Name: _____

Date of Birth: ___/___/___ Gender: _____ Ethnicity: _____

Primary Language(s) Spoken: _____

Address: _____

Phone Number(s): _____

Email Address: _____

Home Life: ☐Single ☐Married ☐Domestic Partnership ☐Divorced ☐Widowed

Employment: ☐Full-Time ☐Part-Time ☐Disabled ☐Retired ☐Homemaker ☐Unemployed

Occupation: _____

Emergency Contact:

Name: _____

Address: _____

Phone Number(s): _____

Relationship: ☐Spouse ☐Domestic Partner ☐Parent ☐Friend ☐Child ☐Other

Pharmacy Information:

Name: _____ Phone number: _____

Address: _____

I certify all of the above information to be true

Patient signature: _____ Date: ___/___/_____

YOUR MEDICAL HISTORY

Please list any current medical conditions:

_____

_____

_____

Please list any previous medical conditions:

_____

_____

_____

Current medications:

Medication name	Dose	Frequency

Please list any surgeries and/or hospitalizations and the year they occurred: _____

_____

_____

Do you have any allergies or adverse drug reactions? List the drug and type of reaction: _____

_____

_____

Habits (complete if applicable):

	Tobacco Use	Recreational Drug Use	Alcohol Intake
Type			
Amount per Week			
Did you quit?			
How long ago?			

Do you exercise? How often: _____ What type:_____

Please check off any symptoms that apply to you:

Constitutional

- ☐ Weight gain
- ☐ Weight loss
- ☐ Loss of appetite
- ☐ Fever
- ☐ Weakness
- ☐ History of stroke
- ☐ History of angina or heart attack
- ☐ History of high blood pressure
- ☐ History of thyroid disease

Dermatology

- ☐ Rash
- ☐ Change in color of moles

Ophthalmology

- ☐ Drainage from eyes
- ☐ Blurring of vision
- ☐ Visual changes

ENT

- ☐ Coughing blood
- ☐ Nosebleeds
- ☐ Hearing loss
- ☐ Change in voice
- ☐ Sore throat
- ☐ Ringing in ears
- ☐ Snoring

Endocrinology

- ☐ Fatigue
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Excessive urination

Gastroenterology

- ☐ Difficulty swallowing
- ☐ Abdominal pain
- ☐ Nausea/vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Change in bowel habits

Neurology

- ☐ Headache
- ☐ Tingling numbness
- ☐ Seizures
- ☐ Dizziness

Psychology

- ☐ High stress level normally
- ☐ Depression
- ☐ Sleep disturbances

Musculoskeletal

- ☐ Joint swelling
- ☐ Joint pain
- ☐ Leg cramps
- ☐ Joint stiffness

Respiratory

- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ History of asthma
- ☐ History of COPD

Cardiology

- ☐ Chest pains
- ☐ Palpitations
- ☐ Leg swelling

Women only:

Date of last mammogram: _____

Date of last pap: _____

Date of last menses: _____

Do we manage your GYN care? _____

If no, who do you see? _____

Any other concerns?

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

To the best of your ability, please fill out the boxes for conditions you are aware of in your blood relatives:

	Mother	Father	Paternal Grand-father	Paternal Grand-mother	Maternal Grand-father	Maternal Grand-mother	Brother(s)	Sister(s)
Alive/age								
Deceased (age at death)								
Alcohol/drug abuse								
Cancer (identify type)								
Depression/ Psychiatric								
Diabetes								
Genetic disorders								
Heart Disease								
High Blood Pressure								
Thyroid Disease								
Other								

RELEASE OF INFORMATION TO OTHER PHYSICIANS

Patient Release Form

Authorization to Release Protected Health Information

Patient Name: _____ Date of Birth: ___/____/_____

Address: _____

_____ Phone Number: _____

I authorize the following facility:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

To release my protected health information to:

Modern Family Medicine, Main Line

864 County Line Rd, Suite 17, Bryn Mawr, PA 19010

Phone: 484-222-6222

Fax: 484-380-3612

This request applies to my:

☐ complete medical record

☐ healthcare information limited to the following conditions or dates: _____

_____

Reason/Purpose for disclosure:

☐ medical

☐ legal

☐ financial

☐ personal

I have read and understand the information in this authorization.

Patient signature: _____ Date: ___/___/_____

RELEASE OF INFORMATION TO FAMILY OR FRIENDS (HIPAA)

Patient Release Form

Authorization to Release Protected Health Information

Patient Name: _____ Date of Birth: ___/____/_____

I authorize the following facility:

Modern Family Medicine, Main Line

To release my protected health information to:

Name(s) of family or friend: _____

_____

Please check here if you would NOT like your medical information released to anyone: ☐

This request applies to my:

☐ complete medical record

☐ healthcare information limited to the following conditions or dates: _____

_____

I have read and understand the information in this authorization.

Patient signature: _____ Date: ___/___/_____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Modern Family Medicine or my insurance company to release any information required to process my claims.

In addition, I acknowledge that I have been informed of Modern Family Medicine's Notice of Privacy Practices. I understand that Modern Family Medicine is a HIPAA compliant office. As a patient, I have the right to obtain a copy of the Notice of Privacy Practices at any time.

Are you the responsible party? ☐ yes ☐ no

If no, who is responsible?

Name: _____ Phone number: _____

Patient signature: _____ Date: ___/___/_____

PAYMENT POLICY

Our mission at Modern Family Medicine is to deliver excellent and personal care that positively impacts people in a changing healthcare system. Our payment policy was created to reduce administrative costs, to keep our fees as low as possible for our patients.

Payment is required at time of service. Any applicable co-payments, co-insurance, negotiated payment plans, and/or deductibles are due at the time of service. For patients with medical insurance benefits, we will bill your insurance. For patients without insurance, we have a menu of out of pocket options. All charges incurred at Modern Family Medicine are ultimately the responsibility of the patient, regardless of insurance benefits.

We accept payment in the form of cash, check, or credit card. A fee of $50 will be charged for returned checks.

At Modern Family Medicine we want to manage our time efficiently so that we can deliver excellent personal care to our patients. We request a 24 hour notice for all cancellations or reschedules. If you no-show for your appointment, you will be charged a **$50 fee** on the second occurrence. If you same-day cancel or reschedule your appointment, you will be charged a **$25 fee**. These fee are not covered by insurance and are the sole responsibility of the patient. Please understand this policy is to ensure efficient time management so that all patients get the time they need with our medical providers.

Patient signature: _____ Date: ___/___/_____

OFFICE POLICIES

Patients will be seen at their SCHEDULED appointment time whether you arrive early or not. If you are more than 15 minutes late to your appointment without calling the office, you will be marked as a no show and will have to reschedule.

All children under the age of 13 ALWAYS NEED to have a parent or guardian supervising them. We are NOT responsible for your children.

Dr. Ho sees many patients daily, whether it is in the office or in a nursing home. If you call and wish to speak with him immediately, we will try our best to accommodate you. Furthermore, your name will be put on a call back list at his discretion.

If you need a refill of a medication, you MUST contact your PHARMACY and advise them, also making sure they are contacting Dr. Ho at this location with our correct information.

Referrals are a common thing with some insurances in order to see a specialist. When calling us with a referral request you MUST have the specialist's NPI number and diagnosis codes, or we cannot process your request. Referrals will not be given after your specialist's services have been rendered. It is then between you, your specialist, and your insurance carrier.

We offer a limited number of same day appointments available on most days. Please call early in the morning as these spots fill up quickly. Same day appointments may NOT be available but our team will do everything they can to accommodate you.

Although it is an infrequent occurrence, a patient may be terminated from the office and given 30 days to locate another medical office for their continued care. Patient termination is at the discretion of Modern Family Medicine. Common reasons for termination include but are not limited to: use of foul language, chronic noncompliance with recommended therapy, abusive behavior towards staff in office or over the phone.

Your health insurance is a contract between you and your insurance carrier. It is your responsibility to know the terms of your policy regarding coverage, co-pays, co-insurance(s) deductibles and non-covered services. If you have any questions about your insurance, you will need to contact your carrier directly. Current insurance cards must be presented at every appointment.

New prescriptions REQUIRE an office visit; no antibiotics will be given over the phone without being seen. Narcotics REQUIRE an office visit every month and will not be refilled if stolen, lost, or prescribed by another physician.

It is the responsibility of the patient to provide us with their past medical records if you decide to obtain them.

I have read and understand the office polices here at Modern Family Medicine.

Patient signature: _____ Date: ___/___/_____