TOHICKON INTERNAL MEDICINE

NEW PATIENT INTAKE FORM

2019

Welcome. *It is our sincere desire to provide you with quality, comprehensive health care. To these ends it is important we gather a detailed picture of your health and health related issues. Please complete this form thoroughly, legibly and accurately. The final page has space for further details you wish to include. The privacy of your health information will become a legally protected part of your medical record. Thank you.*

PATIENT INFORMATION- ***DATE_____***

Patient Name: _____ Date of Birth: _____ Male ☐ Female ☐

Previous Last Name: _____ Marital Status: S M D W DP

Nickname: _____ Spouse Name: _____

Parent/Legal Guardian Name: _____

State/Country of Birth: _____ Special Communication Needs: _____

Occupation:_____ Employer: _____

Language: _____ Race: _____ Decline ☐ Ethnicity: _____ Decline ☐

Are you a Veteran? ☐ NO ☐ YES Organ Donor? ☐ NO ☐ YES Right Handed ☐ Left Handed ☐

PATIENT CONTACT INFORMATION- **Copy of Driver's License Provided ☐**

Address: _____ City: _____

State: _____Zip:_____County:_____Preferred Phone Number: _____

Is this phone number? ☐ Cell ☐ Home ☐ Work *May we leave detailed messages at this phone?* ☐ NO ☐ YES

Secondary Phone:_____ Email: _____

EMERGENCY CONTACT INFORMATION-

Name:	Relationship:	Phone Number:	Address:

I hereby authorize ***Doylestown Healthcare Partnership*** *to discuss and or release my PHI (protected health information) to:* ***Myself Only*** ☐

Name:	Relationship:	Phone:

ADVANCE CARE DIRECTIVE - Do you have an Advance Directive or Living Will? ☐ NO ☐ YES

Have you designated a Durable Power of Attorney? ☐ NO ☐ YES If yes please enter information below

Name:	Relationship:	Phone Number:	Date:

SPECIALISTS CONTACT INFORMATION- (Please provide first and last names)

Name	Office Phone	Location
Cardiologist:		
Eye Doctor:		
Gynecologist:		
Endocrinologist:		
Urologist:		
Other:		

Doylestown Healthcare PARTNERSHIP

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

Wellness Screening History	***Date***	***Address***	***Result***
Wellness/Routine Physical Exam			
Colonoscopy			
Mammogram			
Dexa (Bone Density) Scan			
Pap Smear			
PSA			
Full Body Skin Cancer Exam			
Hepatitis C Screening			
Diabetic Eye Exam			

Adult Vaccination/Immunization History ***(If available please attach childhood immunizations separately)***

	Date		Date		Date
Tetanus		Zoster		Prevnar 13	
TDAP		Shingrix		Pneumovax 23	

Health History- Have you ever been diagnosed with any of the following: **Reconciled** ☐

☐ Measles/ Mumps	☐ Gout	☐ Seizures / Epilepsy	☐ Bone/Joint Disorder	☐ Pneumonia
☐ Chicken Pox	☐ Stomach Ulcer	☐ Parkinson's Disease	☐ Eye Disease	☐ Asthma
☐ Rheumatic Fever	☐ Reflux Disease	☐ Multiple Sclerosis	☐ Glaucoma	☐ Seasonal Allergies
☐ Scarlet Fever	☐ Gall Bladder	☐ High Blood Pressure	☐ Kidney Disease	☐ Emphysema / COPD
☐ Polio	☐ Pancreatitis	☐ Stroke	☐ Kidney Stone	☐ Pulmonary Clotting
☐ Lyme Disease	☐ Colitis	☐ Heart Disease / CAD	☐ Urinary Disorders	☐ Depression
☐ Tuberculosis	☐ Diverticulitis	☐ Heart Attack	☐ Erectile Dysfunction	☐ Anxiety
☐ Diabetes	☐ Irritable Bowel	☐ Heart Murmur	☐ Prostate Disease	☐ Eating Disorder
☐ Sleep Apnea	☐ Hepatitis	☐ Heart Failure	☐ Reproductive Issues	☐ Psychiatric Care
☐ Anemia	☐ Liver Disease	☐ High Cholesterol	☐ Menstrual Problems	☐ Drug Addiction
☐ Bleeding Disorder	☐ Thyroid Disorder	☐ Arthritis	☐ Vaginal Infection	☐ Alcoholism
☐ Blood Clot	☐ Migraines/Headache	☐ Osteoporosis	☐ Breast Lump	☐ Sexual Dysfunction
☐ Cancer Type:_____	☐ Autoimmune Disease Type:_____	☐ Peripheral Vascular Disease	☐ Skin Disease Type:_____	☐ STD Type:_____
Other Health Conditions:				
Blood Transfusion: ☐ NO ☐ YES If yes, date: Reason:				

Surgical History- *None* ☐ *Details Attached* ☐ **Reconciled** ☐

Procedure:	Date:

CURRENT MEDICATIONS WITH DOSAGES- *None* ☐ *Details Attached* ☐ **Reconciled** ☐

Allergies- ☐ No Known Drug Allergies Latex: Yes ☐ No ☐ **Reconciled** ☐

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Patient Name: _____ *Date of Birth:* _____

SOCIAL HISTORY- ***Details Attached*** ☐ ***Reconciled*** ☐

Tobacco Use: ☐ YES ☐ NO ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chew Amount per day: _____ Number of years you have used tobacco: _____ ☐ QUIT Years quit:_____	Alcohol Consumption: ☐ YES ☐ NO Number of drinks per week:_____ Preferred drink (ie: beer, wine, spirits): _____ ☐ QUIT Years quit:_____	Recreational Drug Use: ☐ YES ☐ NO Type: _____ Amount per week:_____ Last used:_____ ☐ QUIT Years quit:_____
Caffeine: ☐ YES ☐ NO # of caffeine drinks per day:_____	Regular Exercise: ☐ YES ☐ NO Type exercise:_____ How often:_____	Do you share a home with anyone else? ☐ YES ☐ NO ☐ Spouse ☐ ___ Children ☐__Friend
Are you regularly exposed to second- hand smoke or other potentially harmful substances at home or work? ☐ YES ☐ NO If so what?	Do you routinely need physical assistance with activities of daily living such as cooking, dressing, hygiene? ☐ YES ☐ NO	Are guns kept in your home: ☐ YES ☐ NO If yes is gun safety a priority at home? ☐ YES ☐ NO
Does everyone in your home receive all routinely recommended immunizations? ☐ YES ☐ NO	Is it important to you that you always wear your seatbelt? ☐ YES ☐ NO	Do you have working smoke detectors in your home? ☐ YES ☐ NO
Do you have regular problems with a lack of food in your home? ☐ YES ☐ NO	Do you have regular problems with transportation? ☐ YES ☐ NO	Do you have regular problems paying for the following: Housing ☐ YES ☐ NO Medications ☐ YES ☐ NO
Are you in an abusive relationship or afraid of physical harm from anyone you know? ☐ YES ☐ NO	Are you at risk of acquiring HIV infection or other sexually transmitted disease? ☐ YES ☐ NO	Do any members of your family have genetically linked health problems? ☐ YES ☐ NO

Over the past two weeks, how often have you been bothered by any of the following?

	Not at All- 0	Several Days- 1	Half the Days- 2	Nearly Every Day- 3
Little interest or pleasure in doing things				
Feeling depressed or hopeless				

If 65 years or older please answer the following:

Have you felt unsteady or fallen more than once in the past year?	Yes ☐	No ☐
Can you switch a light on/off easily from your bed without fear of falling?	Yes ☐	No ☐
Are floors and walkways in your home safe and in good repair?	Yes ☐	No ☐
Is it difficult to get out of bed or off a chair or toilet without assistance?	Yes ☐	No ☐
Is the lighting in your home sufficient for you to see safely?	Yes ☐	No ☐

FAMILY HISTORY- **Reconciled** ☐

Relation	Current Age, if living	Age at Death	High Blood Pressure	Heart Disease	Stroke	Cancer	Diabetes	Glaucoma	Asthma	Seizures	Bleeding Disorder
Father			☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather			☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather			☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling			☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling			☐	☐	☐	☐	☐	☐	☐	☐	☐

Patient Name: _____ Date of Birth: _____

ADDITIONAL NOTES/DETAILS-

Reviewed by Physician:_____Date:_____

TOHICKON INTERNAL MEDICINE, LLC CONSENT

This is a Medical Information Consent required by law to ensure that you are aware the ways in which Tohickon Internal Medicine, LLC may use or disclose your health information for treatment.

Your Medical Health Information is Treated as Confidential. In general, any information that is about your health, the health care you receive, or payment for that care, is considered confidential and protected by Tohickon Internal Medicine, LLC. How we use and disclose medical information is described in detail in the Tohickon Internal Medicine, LLC Medical Information Notice, which is available for your review by asking the Health Information Department or any member of our staff.

Using and Disclosing Information for Treatment, Payment and Health Care Operations. Tohickon Internal Medicine, LLC is permitted by law to use and disclose your medical information for treatment, payment and health care operations. Tohickon Internal Medicine, LLC participates in various health information exchanges where we disclose your health information, as permitted by law, to other health care providers for your treatment, or for payment or other health care operations purposes. For instance, we can share necessary information in order to bill your insurer. Please read the Notice for a complete description of the ways in which we use and disclose your medical information for these purposes.

Restrictions on How Tohickon Internal Medicine, LLC Uses and Discloses Your Health Information. You can ask Tohickon Internal Medicine, LLC to restrict the medical information used or shared about you for treatment, payment and health care operations. We may not be able to agree with your request, and will tell you so. If we do not agree to your request, we are bound to follow it.

Your Right to Revoke This Consent. You can take away this Consent at any time, as long as you do so in writing. Please consult the Notice or the Health Information Department for more information on how to revoke this Consent. Your revocation will not apply to any use or disclosure of your medical information by Tohickon Internal Medicine, LLC prior to the revocation and based on the original Consent.

Tohickon Internal Medicine, LLC' Right to Change Its Notice Form. We have the right to change our Notice at any time. If we do so, you may obtain a copy of the revised Notice by consulting the Health Information Department or any member of our staff.

Please sign below to indicate that you have read this Consent and agree with its terms.

_____ _____

Date Patient Signature

_____ _____

Date of Birth Print name of Patient

Revised date- 5/10/2018

TOHICKON INTERNAL MEDICINE 1456 FERRY RD. STE. 400 DOYLESTOWN, PA 18901	*Patient Name:* *D.O.B.*

Surescripts Medication Information Consent

What is Surescripts?

Surescripts operates an electronic network which securely connects pharmacies, care providers and benefit managers by allowing for the private electronic movement of current and historical clinical health information between different health systems, including ours here at Tohickon Internal Medicine. This information includes accurate histories of dispensed patient medications.

What is Medication Information and how is it used?

The Surescripts Medication History service allows healthcare professionals to access a patient's dispensed medication history across different unrelated prescribers. This service can be used in the course of providing routine health care as well as during emergencies. In both cases, accurate patient medication information enables healthcare providers to make safe, accurately informed treatment plans with their patients.

Consent

I acknowledge that by signing this form I consent to Tohickon Internal Medicine accessing and receiving my medication history data from the Surescripts network. I understand I may revoke this consent at any time by providing written notification to Tohickon Internal Medicine.

*Patient Signature*_____ *Date*:_____

If patient is under 18 years of age the signature of a parent or guardian is required'

*Parent or Guardian*_____ *Date:*_____

1456 Ferry Road, Suite 400 Doylestown, Pennsylvania 18901
Phone: 267-880-6350 Fax: 267-880-6592

www.tohickoninternalmedicine.com

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF HEALTH INFORMATION

Which methods of communication may we use to contact you?

- ❑ Home phone – leave message to return call *without* details
- ❑ Home phone – leave message *with* details
- ❑ Cell phone – leave message to return call *without* details
- ❑ Cell phone – leave message *with* details
- ❑ Letter *with* details
- ❑ E-mail *with* details

With whom do you authorize us to discuss your health information?

NAME (please print)	RELATIONSHIP TO PATIENT	Contact Number	Date
NAME	RELATIONSHIP TO PATIENT	Contact Number	Date
NAME	RELATIONSHIP TO PATIENT	Contact Number	Date
NAME	RELATIONSHIP TO PATIENT	Contact Number	Date

THIS AUTHORIZATION MAY BE REVOKED OR REPLACED AT ANY TIME.

SIGNING THIS FORM WILL RENDER ANY PRIVIOUSLY SIGNED FORM ON FILE VOID

SIGNATURE OF PATIENT / LEGAL GUARDIAN / LEGAL REPRESENTATIVE	**DATE OF BIRTH**	**DATE**
NAME OF LEGAL GUARDIAN / LEGAL REPRESENTATIVE (*Please Print*)	**RELATIONSHIP TO PATIENT**	

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2019 Revised OFFICE POLICIES

It is our mission to efficiently deliver high-quality, comprehensive, medical care to you- our valued patient. To achieve this goal we request all patients adhere to the following administrative policies. Your cooperation is greatly appreciated. Noncompliance with the practices policies may result in fees as stated below.

FEE POLICIES

1. **If you cannot keep an appointment, you are responsible for notifying the office a minimum of 12 hours in advance. Fee for missed appointment without minimum 24 hours notification**…… $25.00
2. We accept cash, checks, credit and debit cards. **Returned check fee** …… $50.00
3. Bill payments to the practice are due within 30 days of receipt. **Overdue payment fee** …… $10.00
4. Unaddressed overdue bills of 120+ days will be sent for collection services. **Collection fee** …… $55.00
5. FORMS-Completion of health forms requiring physician signature…***(fee based on form complexity)***……..$10.00-25.00
6. Copying of your medical record upon your signed request ……***per page fee- total not to exceed***…… $40.00

MEDICATION REFILLS

- **Please request your medication refills at the time of your visits. This provides patients the most timely refill service.**
- Allow **2 business days** to process refill requests made by phone or patient portal email.
- **Please note**- medications ordered elsewhere (i.e.: specialist) must be refilled by the original ordering physician unless previously approved by your provider.

INSURANCE REFERRALS

- 48 hours notice is requested for non-urgent referrals.
- All referrals are created and transmitted electronically. Paper copies are not necessary.

TEST RESULTS

- **Results of tests ordered by other doctors (i.e.: specialist) are not available through this office. Please contact ordering physician's office or facility for results.**
- Lab testing can take 2-30 days to process depending on tests ordered. You will be contacted regarding results within 48 hours of **receipt of all test results** ordered by our providers.
- Lab results ordered by our providers can be viewed and downloaded through your online patient portal. Mailed copies of test results are available directly from the lab upon your request at the time of testing. We do not mail test results.

I_____ have read, understand and agree to the above policies.

(*Please Print)* ***DOB***

SIGNATURE OF PATIENT / LEGAL GUARDIAN / LEGAL REPRESENTATIVE **DATE**

NAME OF LEGAL GUARDIAN / LEGAL REPRESENTATIVE (*Please Print*) **RELATIONSHIP TO PATIENT**