

DELAWARE VALLEY I.D. ASSOCIATES, P.C.

100 E. Lancaster Avenue • Lankenau MOB East 556 • Wynnewood, PA 19096
Phone 610-896-0210 • Fax 610-896-5101

Jerome Santoro, M.D.
Lawrence L. Livornese Jr., M.D.
Bevin L. Dolan, M.D.
Fredy Chaparro, M.D.

Mark J. Ingerman, M.D.
Brett C. Gilbert, D.O.
Kiran Paramatmuni, M.D.

www.delawarevalleyid.com

Infectious Diseases • Infusion Services • Travel Medicine

Appointment Checklist

- _____ Be certain that you or your doctor has sent us any and all pertinent information regarding the reason for your appointment.
- _____ If a referral is required by your insurance plan, be certain to have your Primary Care Physician process the referral. (See our provider numbers below.)
- _____ Complete the Patient Registration Form.
- _____ Complete the Medical History Form. List your current medications INCLUDING strength and dosage or bring a separate list.
- _____ Complete the Review of Systems Form. (Please check any that apply to you NOW.)
- _____ Bring your current Medical Insurance Card(s).
- _____ Bring Photo ID.
- _____ Be prepared to pay your co-pay by cash, check, or credit card upon check in.

Entering the Lankenau Campus from Lancaster Avenue

- Follow the driveway to the VISITOR PARKING Garage (B)
- You will enter the medical building on the GROUND FLOOR of the West Building
- Proceed past the Pharmacy and Information Desk into the Atrium
- Make a LEFT past the Atrium Café
- Follow to the lobby of the East Building
- Take the elevator to the 5th floor
- Turn left upon leaving the elevator to Suite 556

Provider Numbers

Keystone Health Plan East **1871517540**

Aetna **1871517540**

Health Partners **7047**

Keystone First (formerly Keystone Mercy) no longer requires referrals

**Delaware Valley ID Associates
PATIENT REGISTRATION FORM**

Patient Last Name: _____ First: _____ Middle Init: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone #: _____ 2nd Phone #: _____ 3rd Phone #: _____

May we leave a message regarding confidential information pertaining to your health status and/or test results on your...

Preferred Phone? Y or N 2nd Preferred Phone?: Y or N 3rd Preferred Phone?: Y or N

Date of Birth: _____ Email: _____ Sex: Male or Female

Race: White African American Hispanic Asian American Indian Native Hawaiian Other _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino Other _____

Is your preferred language ENGLISH? Y or N If no, please indicate preferred language: _____

IN CASE OF EMERGENCY, WHOM SHOULD WE CONTACT?

Name: _____ Relationship: _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

May we share your personal health information with the emergency contact? Y or N

Is there a person(s) with whom we may share your personal health information (other than the emergency contact)? Y or N

If yes, Name: _____ Relationship: _____ Phone #: _____

Name : _____ Relationship: _____ Phone #: _____

FAMILY PHYSICIAN: _____ Phone# _____

Address, City, State _____ Fax# _____

REFERRING PHYSICIAN: _____ Phone# _____

Address, City, State _____ Fax# _____

LOCAL PHARMACY: _____ Phone# _____

Address, City, State: _____

MAIL ORDER PHARMACY: _____ Phone #: _____

Address, City, State: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I understand and agree that Delaware Valley I.D. Associates, P.C. and its employees and agents may use and disclose protected health information about me for payment, treatment and/or health care options.

I request that payment of authorized insurance benefits be made either to me or on my behalf to Delaware Valley I.D. associates, P.C. for any services furnished to me by Delaware Valley I.D. Associates, P.C. and its employees and agents. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient or Guardian Signature

Date

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. ePrescribing greatly reduces medication errors, and enhances convenience for the patient while maximizing patient safety. The ePrescribe Program includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

By signing this consent form you are agreeing that Delaware Valley ID Associates may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Delaware Valley ID Associates to enroll me in the ePrescribe Program.

Print Patient Name

Date of birth

Signature of Patient (or Guardian)

Medical History

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

Height: _____ **Weight:** _____ **Occupation:** _____ **Married** **Single** **Divorced**

Smoker: **Yes** **Stopped** **Never** **If Yes or Stopped: # of Years** _____ **#Packs/day** _____

Alcohol Use: **Frequent** **Occasional** **Never**

Drug Use: **Frequent** **Occasional** **Never** **Substance(s)** _____

Present Complaint: _____

Medical History

Surgical History

	Yes	Operation	Date
High Blood Pressure	<input type="checkbox"/>	_____	_____
Heart Disease	<input type="checkbox"/>	_____	_____
Heart Murmur	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	_____	_____
Bleeding Tendency	<input type="checkbox"/>	_____	_____
Cancer	<input type="checkbox"/>	_____	_____
Hepatitis	<input type="checkbox"/>	Hospitalization (other than surgical)	
Transfusion	<input type="checkbox"/>	Place	Reason
TB/Positive Skin Test	<input type="checkbox"/>	_____	Date
Asthma/Emphysema	<input type="checkbox"/>	_____	_____
Other _____	<input type="checkbox"/>	_____	_____
Other _____	<input type="checkbox"/>	_____	_____
Other _____	<input type="checkbox"/>	_____	_____

ALLERGIES: _____

Medication

Dose & Frequency

Duration

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Yes

Relative

Alive or Deceased

High Blood Pressure	<input type="checkbox"/>	_____	_____
Heart Disease	<input type="checkbox"/>	_____	_____
Stroke	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	_____	_____
Emphysema or Asthma	<input type="checkbox"/>	_____	_____
Kidney Disease	<input type="checkbox"/>	_____	_____
Cancer	<input type="checkbox"/>	_____	_____
Aneurysm	<input type="checkbox"/>	_____	_____
Autoimmune Disease	<input type="checkbox"/>	_____	_____

Review of Systems:

Yes

Yes

General

- Weight Change
- Malaise
- Fevers, Chills, Sweats
- Lumps or Bumps
- Frequent Infections (Colds)
- Loss of Appetite

Cardio-Pulmonary

- Cough
- Wheezing
- Cough with Blood
- Chest Pain (Angina)
- Leg Swelling
- Palpitations
- Shortness of Breath
- Rheumatic Fever
- Frequent Urination
- Leg Pain with Walking
- Pneumonia or Pleurisy

Eyes, Ears, Nose, & Throat

- Trouble Seeing
- Double Vision
- Tearing
- Dry Eyes
- Glasses
- Hoarseness, Sore Throat
- Nose Bleeds
- Sinus Trouble
- Ear Noise
- Ear Discharge
- Dry Mouth

Gastro-Intestinal

- Heartburn
- Hernia
- Nausea or Vomiting
- Abdominal Pain
- Ulcers
- Excessive Gas
- Jaundice (Yellowness)
- Blood in Stool
- Rectal Bleeding
- Constipation
- Diarrhea
- Hemorrhoids
- Swallowing Difficulty
- Gall Stones

Genito-Urinary

- Painful Urination
- Urgent Urination
- Frequent Urination
- Trouble with Stream
- Nighttime Urination
- Past Urinary Tract Infection
- Kidney Stone
- Male Impotence
- Discharge
- Loss of Urine
- Blood in Urine
- Sexually active

Genito-Urinary (Continued)

- Regular Periods
- Menopause (Age)
- Bleeding Between Periods or Spotting
- Past Pelvic Infection
- Still Births
- Abortions/Miscarriages
- Number of Children

Neuro-Muscular

- Weakness
- Arthritis
- Broken Bones
- Pain in Joints
- Swollen Joints
- Muscle Pain
- Epilepsy
- Headache
- Behavioral Change
- Mood Changes/Sadness/Hopelessness
- Fainting
- Numbness or Tingling
- Phlebitis
- Back Problems
- Vertigo/Dizziness

Metabolic or Constitutional Complaints

- Excessive Thirst
- Excessive Hunger
- Excessive Urination
- Heat Intolerance
- Cold Intolerance
- Excessive Weight Gain
- Excessive Weight Loss
- Thyroid Disease
- Gout

Dermatology

- Unusual Moles
- Rash
- Loss of Hair
- Brittle Nails
- Hives
- Psoriasis

Miscellaneous

- Breast Lumps
- Breast Discharge
- Coffee or Tea (More than 3 cups)
- Special Diet (Specify)
- Unusual Habits (Specify)
- _____
- _____
- Last Chest X-ray _____
- Last Lab Tests _____
- Last Cardiogram _____
- Last Mammogram _____
- Do you feel unsafe in your
current relationship _____
- Recent Travel _____
- Animal Exposure _____
- Exercise Habits _____

Name: _____

Reviewed with patient _____

Date of Birth: _____