Delaware Valley I.D. Associates
Infectious Diseases & Travel Medicine

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100 E. Lancaster Avenue
Lankenau MOB East 556
Wynnewood, PA 19096

TEL 610-896-0210
FAX 610-896-5101

www.delawarevalleyid.com

Medical Appointment Checklist

_____ Be certain that you or your doctor has sent us any and all pertinent information regarding the reason for your appointment. Please fax that information to 610-896-5101.

_____ If a referral is required by your insurance plan, be certain to have your Primary Care Physician process the referral. Our provider number is 1871517540.

_____ 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.

Directions to our suite – MOB East 556

-Enter the Lankenau Medical Center 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

Delaware Valley ID Associates
PATIENT REGISTRATION FORM

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

Date of Birth: _____ Gender: _____ Email:_____

Address:_____

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

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

Home Phone? Y or N Cell Phone?: Y or N Work Phone?: Y or N

Do you have a living will? Y or N

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: _____

EMERGENCY CONTACT(S)

1. Name:_____ Relationship: _____

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

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

2. Name:_____ Relationship: _____

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

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

FAMILY PHYSICIAN: _____ Phone#_____

REFERRING PHYSICIAN: _____ Phone#_____

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

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	**Yes**
High Blood Pressure	☐
Heart Disease	☐
Heart Murmur	☐
Diabetes	☐
Bleeding Tendency	☐
Cancer	☐
Hepatitis	☐
Transfusion	☐
TB/Positive Skin Test	☐
Asthma/Emphysema	☐
Other_____	☐
Other_____	☐
Other_____	☐

Surgical History

Operation	**Date**

Hospitalization (other than surgical)

Place	**Reason**	**Date**

ALLERGIES:_____

Medication	**Dose & Frequency**	**Duration**

Family History	**Yes**	**Relative**	**Alive or Deceased**
High Blood Pressure	☐		
Heart Disease	☐		
Stroke	☐		
Diabetes	☐		
Emphysema or Asthma	☐		
Kidney Disease	☐		
Cancer	☐		
Aneurysm	☐		
Autoimmune Disease	☐		

Review of Systems: **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:_____

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)