Steven Rosenzweig, M.D.

Patient Registration Form

Registration form page 1

Today's date	
Patient name	Date of Birth
Address	
Best phone contact number: ☐ Cell ☐ Home ☐ Work	Alternative contact number: ☐ Cell ☐ Home ☐ Work

PRIVACY

WE FOLLOW STANDARD PRIVACY PRACTICES. DID YOU WANT TO RECEIVE A WRITTEN COPY TO READ?

☐ No thanks: I don't need to receive or review a copy of the Notice of Privacy Practices

☐ I have received and reviewed a copy of the Notice of Privacy Practices

WE NEED YOUR PERMISSION TO USE EMAIL

☐ I give permission for my email address to be used for appointment scheduling and reminders.

☐ I give permission for Dr. Rosenzweig and his staff to correspond with me by email about my health information. Every effort is made to protect the confidentiality of all email correspondence. Email is a convenience but is optional.

Email address:

WE NEED YOUR PERMISSION FOR DR. ROSENZWEIG TO ACCESS YOUR ELECTRONIC MEDICAL RECORDS

☐ Yes, I give Dr. Rosenzweig permission to access available records.

WE NEED YOUR PERMISSION FOR DR. ROSENZWEIG TO DISCLOSE HEALTH INFORMATION TO YOU'RE YOUR HEALTH INSURANCE:

☐ Yes, I give permission to bill my insurance company and send a report back to my referring physician.

WE NEED YOUR PERMISSION FOR DR. ROSENZWEIG TO SEND HIS NOTES TO YOUR OTHER TREATING PHYSICIANS AND THERAPISTS:

☐ Yes, I give permission for Dr. Rosenzweig to send a report to any of my physicians or therapists.

☐ No, Dr. Rosenzweig should only send my information to the following physicians or therapists (please list):

IF THERE ARE FAMILY MEMBERS OR OTHERS WITH WHOM YOU PERMIT DR. ROSENZWEIG TO DISCLOSE YOUR MEDICAL INFORMATION LIST THEM HERE:

X_____

Signature of Patient or Authorized Health Representative Date

Patient name: _____

Registration form page 2

INSURANCE INFORMATION

CO-PAYS: Due at the time of you visit. Dr. Rosenzweig is listed as a specialist.
Please call your insurance company ahead of time to determine your co-pay. We will not be able to do that for you.

INSURANCE REFERRALS: If you plan requires a referral form your PCP, please make sure we have that prior to your visit or we will have to reschedule.

Please provide us with a copy of your insurance cards *or* complete this section

Primary Insurance Company:

ID# Group #

Name of policy holder

Relation to patient

Secondary Insurance Company:

ID# Group #

Name of policy holder

Relation to patient

FINANCIAL RESPONSIBILITY

Name of Person Responsible for Payments:

Relationship to Patient:

Address and Phone Number (if different from above):

Patients are responsible for obtaining referrals if required by their insurance plan. This must be done by the time of the office visit. Otherwise we will need to bill you directly. Patients are responsible for the payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan. Payment is due at the time of service.

Patients may be responsible for additional charges not covered by insurance:

- Charge for missed appointments without 1 complete business day advance notice: $150 for missed initial visit; $75 for missed follow-up visit.
- Charge for returned checks
- Charge to established patients for telemedicine or telephone consultations not covered by your insurance plan – these are billed after the first 10 minutes at a prorated, hourly rate
- Charge for the copying and distribution of patient medical records
- Laboratory and other testing – Patients are responsible for verifying their own insurance coverage for any testing ordered by Dr. Rosenzweig.

AUTHORIZATION AND RELEASE

I authorize release of any information concerning my (this patient's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise provided to me directly to Dr. Rosenzweig for his services

X Signature of Patient or Guardian: Date:

NAME PRINTED:

Steven Rosenzweig, M.D.

Medical History Intake Form

Patient Name: **Date of Birth:**

Preferred Pronouns:

How would you prefer to be addressed by Dr. Steve?

Reason for Consultation: Please list the major issue(s) here.

Healthcare Team: Who is the main physician in charge of your treatment (PCP or specialist)?

PART 1—MEDICAL HISTORY

You can skip filling out PART 1 if:
You have a written summary of this information and provide it with this document, or
You have given permission to access your Penn, Jefferson, or Main Line Health electronic records

Past Medical History. Record or attach list of all medical conditions, diagnoses, or medical problems for which you have been treated or list them here.

Major Surgeries: Please list all major surgeries with dates.

Major Physical Injuries: Please list with dates.

Allergies:

Medications	**Nature of reaction**	**Severity**

Other (food, latex, environmental, etc.)

Patient name: _____

Medications: Record or attach a list of ALL prescription and over the counter medicines with doses.

Supplements / Herbal Medicines / Homeopathics: Attach or send a complete list with doses or list here:

Advance Care Planning – Living Will and Substitute Decision-Maker:

Have you appointed a substitute decision-maker if you can't make your own medical decisions even temporarily? This is also called having a healthcare proxy or giving someone medical power of attorney.

Name of substitute decision-maker:

Do you have a living will?

Do you need more information about this?

Family Medical History: Medical problems of your family members (including cancer, early heart disease, high blood pressure, diabetes)?

Father:

Mother:

Siblings:

Children:

Other family members with cancer, genetic diseases or other significant diagnoses:

PART 2—SOCIAL HISTORY

Skip any questions you prefer not to answer

Substance use:

Tobacco: Present use? Past use (number years)?

Are you in recovery?

Have you ever felt you ought to cut down on your drinking or drug use?
Have people annoyed you by criticizing your drinking or drug use?
Have you felt bad or guilty about your drinking or drug use?

Patient name: _____

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Social Support:

Is your home situation safe and stable? With whom do you live?

Do you have a good social support or family, friends or neighbors?

In the past 12 months, did you worry that your food would run out or did it run out?

Wellness Practices:

What is your diet like?

Exercise – type, intensity and frequency:

Mind-body-spirit practices (meditation, yoga, Tai Qi, prayer, etc.):

Alternative or complementary therapies:

Biographical:
Please share about your background (interests, occupation, education, anything about yourself you'd like Dr Steve to know.

Spiritual or philosophical orientation: Please share something about what gives your life meaning or a sense of connection to something greater.

What else would it be helpful for Dr. Rosenzweig to know about you?

Patient name: _____

PART 3—SYMPTOM REVIEW

Symptom Checklist #1. Please rate symptom intensity in general **over the past week**. **0** means no symptoms at all and **10** means worst imaginable.

Pain……...0-1-2-3-4-5-6-7-8-9-10	Shortness of breath….0-1-2-3-4-5-6-7-8-9-10
Fatigue/tiredness…0-1-2-3-4-5-6-7-8-9-10	Depressed / sad……0-1-2-3-4-5-6-7-8-9-10
Drowsiness……..0-1-2-3-4-5-6-7-8-9-10	Anxiety/restlessness…0-1-2-3-4-5-6-7-8-9-10
Nausea…….0-1-2-3-4-5-6-7-8-9-10	*Overall <u>diminished</u>* sense of wellbeing…..0-1-2-3-4-5-6-7-8-9-10
Loss of appetite ….0-1-2-3-4-5-6-7-8-9-10	

Symptom Checklist #2. Please indicate **CURRENT or RECENT** symptoms only:

General	☐ Weight loss ☐ Weight gain ☐ Sleep problems ☐ Sweats ☐ Fatigue
Eyes	☐ Dryness ☐ Vision change
ENT	☐ Hearing change ☐ Ringing in ears ☐ Trouble swallowing ☐ Sinus problems
Heart/Circ	☐ Chest pain with exertion ☐ Elevated blood pressures on home monitoring ☐ Irregular heart beat
Breathing	☐ Cough ☐ Wheezing ☐ Pain with breathing
GI	☐ Constipation ☐ Diarrhea ☐ Excessive gas ☐ Blood or abnormal color of bowel movement
Urological	☐ Pain with urination ☐ Abnormal frequency of urination
Muscle/Joint	☐ Muscle pain ☐ Muscle cramps ☐ Joint pain ☐ Joint stiffness ☐ Joint swelling
Neurologic	☐Faintness or dizziness ☐ Headaches (not just mild & occasional) ☐ Balance problems ☐ Memory problems ☐ Concentration problems
Endocrine	☐ Excessive thirst ☐ Hot flashes ☐ Hair thinning
Blood	☐ Abnormal bleeding ☐ Abnormal bruising
Skin	☐ Rash ☐ Sores ☐ Abnormal bumps
Immune	☐ Hives ☐ Swollen glands ☐ HIV positive status

FEEDBACK:
How could we have made this form or registration process better or more comfortable for you?

Almost done!
Please complete the next pages giving permission for Dr. Rosenzweig to share information with your healthcare team.

Thank you!

RELEASE #1: This form gives permission for records to be sent **TO:** Dr. Rosenzweig

Patient's Name:	**Date of Birth:**

I authorize the following practice(s) to disclose my health information as described below to

Steven Rosenzweig, MD
123 Chestnut Street; Philadelphia, PA 19106
Fax: 888-802-0516; Tel: 215-627-3782

We are NOT requesting:
Psychotherapy notes
Drug and alcohol treatment reports

☑ I am giving permission to include (should this apply to me):
Information about HIV diagnosis and treatment
Information about genetic testing results

NAME OF PHYSICIAN, INDIVIDUAL OR ENTITY	TYPE AND AMOUNT OF INFORMATION
	Recent and future progress notes and test reports

I understand that if I give permission, I have the right to change my mind and revoke it in writing. I also understand that any disclosures already made with my permission cannot be taken back. By signing this Authorization, I understand that any disclosure of information carries the potential for an unauthorized re-disclosure not protected by Federal privacy rules.

SIGNATURE OF PATIENT OR AUTHORIZED HEALTH REPRESENTATIVE	**DATE**

Authorized Health Representative's Name	**Relation to Patient**

RELEASE #2: This form gives permission for Dr. Rosenzweig to send his visit notes and test results TO your other healthcare providers.

Patient's Name:	**Date of Birth:**
I authorize Dr. Rosenzweig to share my medical information with my other healthcare providers.	
NAME OF PHYSICIAN, INDIVIDUAL OR ENTITY	TYPE AND AMOUNT OF INFORMATION Recent and future progress notes
I understand that if I give permission, I have the right to change my mind and revoke it in writing. I also understand that any disclosures already made with my permission cannot be taken back. By signing this Authorization, I understand that any disclosure of information carries the potential for an unauthorized re-disclosure not protected by Federal privacy rules.	
SIGNATURE OF PATIENT OR AUTHORIZED HEALTH REPRESENTATIVE	**DATE**
Authorized Health Representative's Name	**Relation to Patient**