NINTH STREET
INTERNAL MEDICINE ASSOCIATES, LTD.

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PATIENT HEALTH HISTORY FORM DIRECTIONS AND VISIT DAY INSTRUCTIONS

Dear Patient:

THANKS FOR MAKING AN APPOINTMENT TO SEE US!

Prior to your Appointment:

Please complete all the attached forms and bring them with you on the day of your visit.

- ☐ Authorization for Release of Medical Information
- ☐ New Patient Information Form (Pages 1-2)
- ☐ New Patient Health Assessment Forms (Pages 1-3)
- ☐ Past Medical History Form
- ☐ HIPAA Privacy Authorization Form (Pages 1-2)
- ☐ Patient Portal Consent Form

On the Day of your Appointment:

- Please do not wear any perfumes, lotions or oils, since they may interfere with an ECG tracing.
- Please bring a medication list with the names of all prescription and over-the-counter medicines (including vitamins), and the strength of each pill and the number of times per day that you take each of them.

PLEASE NOTE
If you cancel with less than 24 hours' notice or do not show up for your appointment, you will be charged $50.00

Ninth Street Internal Medicine - AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

805 Locust Street. Philadelphia, PA 19107 Office (215) 440-8681 Fax (215) 440-9953

_____ _____

(**Print** Patients Full Name) Birth Date (Mo/Day/Yr)

_____ _____

Street Address Phone (Home)

_____

City, State, Zip

At the request of the individual, I _____, do hereby
(Patient's Name)

Authorize:

_____

Name of Company/Agency/Facility/Person

_____

Street Address

_____

City, State, Zip

To Release DATES OF:

_____

___HISTORY & PHYSICAL ___LABORATORY REPORTS ___ IMMUNIZATION RECORDS
___PROGRESS NOTES ___RADIOLOGY REPORTS ___PAP SMEAR RESULTS
___DIAGNOSTIC TESTING (e.g. colonoscopy, mammogram, dexascan, etc.) ___HOSPITAL RECORDS
___OTHER: _____

INFORMATION RELEASE TO: ***NINTH STREET INTERNAL MEDICINE***

PURPOSE OF DISCLOSURE:

____CHANGE OF DOCTOR ____COORDINATION OF PRIMARY CARE ____OTHER (SPECIFY)

_____

MY RIGHTS:

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I acknowledge that a copy of this authorization may be used in place of its original. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of on the basis of whether or not I sign the authorization.

_____ _____

Signature of Individual or Guardian or Personal Representative of Patient's Estate **Date**

NO DISC PLEASE

NINTH STREET INTERNAL MEDICINE PATIENT NAME: _____ DATE OF BIRTH: _____

New Patient Registration Form

APPOINTMENT DATE: _____

Patient Information

Personal Details

NAME: _____ DATE OF BIRTH: _____

MARITAL STATUS: _____ GENDER: _____

Address Details

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

Contact Details

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ EMAIL: _____

Other Details

PCP: _____ REFERRING DOCTOR: _____

Emergency Contact Details

LAST NAME: _____ FIRST NAME: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

RELATION: _____

Additional Information

Pharmacy

LOCAL PHARMACY NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

Street Address (if different from mailing address)

MAIL ORDER PHARMACY NAME: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

New Patient Registration Form

APPOINTMENT DATE: _____

Patient Information

Employer

NAME: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

Contacts 1 [Optional]

LAST NAME: _____ FIRST NAME: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

RELATION: _____

Contacts 2 [Optional]

LAST NAME: _____ FIRST NAME: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

RELATION: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____

ID# _____ GROUP # _____

GUARANTOR'S NAME: _____ DOB: _____

SECONDARY INSURANCE NAME: _____

ID# _____ GROUP # _____

GUARANTOR'S NAME: _____ DOB: _____

NINTH STREET
INTERNAL MEDICINE ASSOCIATES, LTD.

New Patient Health Assessment Form

Please complete this form in advance of your first physical appointment. Be sure to bring it with you. Use pencil or pen and completely fill in only one circle per question for the attached bubble sheets. The following information is confidential. It is used to evaluate your health and risk factors for disease.

Name_____ Appointment Date_____
Date of Birth_____ Age_____ Birthplace_____
Spouse/Partner's Name_____
Spare time activities_____

What **problems** do you wish to discuss with the doctor during your evaluation today?

_____
_____
_____
_____
_____

Please list the **other doctors** you see regularly:
name _____**specialty**_____

_____
_____
_____
_____
_____

Please list your **allergies** to medication

Drug_____ Reaction_____
Drug_____ Reaction_____
Drug_____ Reaction_____
Drug_____ Reaction_____
Drug_____ Reaction_____

Please list **food and environmental allergies** such as smoke/pollen.

_____
_____
_____
_____
_____

Please list all your regular **medications** *including* birth control, *over-the-counter medicines, vitamins and health food store products*. Please include dosage (strength) and number of times per day.

1_____ 7_____
2_____ 8 _____
3_____ 9_____
4_____ 10 _____
5_____ 11 _____
6_____ 12_____

Past Surgical History *(Please write date and name of surgeon):*

Tonsillectomy_____ Uterus removed (reason)_____
Appendix removed_____ Ovaries removed (one, both and reason) _____
Gallbladder removed_____ C-section(s)_____
Hernia repair (side and type) _____ Hemorrhoid surgery_____
Joint replacement (specify joint(s)) _____
Other Surgeries_____

Immunization/Vaccine history *with dates if possible:*

O Tetanus or **O** Tetanus/Pertussis_____
Influenza (flu) _____
Pneumovax/Pneumonia _____
TB test/PPD and result_____
Meningitis_____
Other_____

Varicella (chicken pox) **O** vaccine or **O** disease_____
Zoster/Shingles vaccine_____
Hepatitis B (3 shots)_____
Hepatitis A (2 shots)_____
MMR_____
HPV_____

Screening tests with *dates and name of provider or hospital:*

Last complete physical exam:_____
Colonoscopy_____
PSA (prostate cancer blood test) men only_____
Pap Test – women only_____
Mammogram – women only_____
DXA bone density scan_____

Family History:

Relationship	Current Age *or* Age at Death		Significant Medical Problems
Mother	_____	_____	_____
Father	_____	_____	_____
#of Sisters ____	_____	_____	_____
#of Brothers ____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse/Partner	_____	_____	_____
#of Children ____	_____	_____	_____
(Son or Daughter)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
#of Grandchildren ____			

Please indicate if any of the above relatives *or* if any grandparents, aunts, uncles have these diseases:

Yes	No		Yes	No	
___	___	asthma	___	___	kidney disease/dialysis
___	___	arthritis	___	___	kidney stones
___	___	blood clotting /bleeding disorder	___	___	alcohol/drug problem
___	___	diabetes	___	___	mental illness/suicide
___	___	stroke	___	___	osteoporosis
___	___	glaucoma/macular degeneration	___	___	cancer (circle type and give age):
___	___	heart attack/atherosclerosis			breast, ovarian, colon, prostate,
___	___	high blood pressure			melanoma, other_____
___	___	high cholesterol	___	___	other_____

NINTH STREET INTERNAL MEDICINE

PATIENT NAME: _____

DATE: _____
APPOINTMENT DATE: _____
PCP: _____

NEW PATIENT HEALTH ASSESSMENT FORM

Social History

Marital Status:
☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Number of People in Household:
☐ 1 ☐ 2 ☐ 3 ☐ 4+

Highest Education Level:
☐ Some High School ☐ High School ☐ Some College ☐ College ☐ Grad School ☐ Post Graduate ☐ Other

Occupation:

_____

How is your life in general?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Disastrous

Special Diet?

_____

Exercise:
☐ Never ☐ Occasional ☐ 2-3 days per week ☐ 3-5 days per week ☐ Every Day

Any questions about sex you would like to discuss with your doctor?
☐ Yes ☐ No

Regular dental care?
☐ Yes ☐ No

Recreational drug use?
☐ Yes ☐ No

Guns in the house?
☐ Yes ☐ No

Regular eye care?
☐ Yes ☐ No

Home smoke detector use?
☐ Yes ☐ No

Does a partner from a current or past relationship make you feel unsafe?
☐ Yes ☐ No

DO YOU HAVE ANY OF THE FOLLOWING?

Constitutional
Falls? ☐ Yes ☐ No
Fatigue? ☐ Yes ☐ No

Cardiology
Chest Pain? ☐ Yes ☐ No
Shortness of Breath? ☐ Yes ☐ No
Palpitations? ☐ Yes ☐ No
Leg Swelling? ☐ Yes ☐ No

Dermatology
Rash? ☐ Yes ☐ No

ENT
Nasal congestion? ☐ Yes ☐ No
Sore throat? ☐ Yes ☐ No
Hearing loss? ☐ Yes ☐ No
Post-nasal drip? ☐ Yes ☐ No
Dizziness? ☐ Yes ☐ No

Gastroenterology
Abdominal Pain? ☐ Yes ☐ No
Nausea? ☐ Yes ☐ No
Vomiting? ☐ Yes ☐ No
Heartburn? ☐ Yes ☐ No

Gastroenterology
Indigestion? ☐ Yes ☐ No
Diarrhea? ☐ Yes ☐ No
Constipation? ☐ Yes ☐ No
Change in bowel habits? ☐ Yes ☐ No
Blood in stool? ☐ Yes ☐ No
Hemorrhoids? ☐ Yes ☐ No

Hematology/Lymph
Bleeding problems? ☐ Yes ☐ No
Clotting problems? ☐ Yes ☐ No

Musculoskeletal
Joint Pain? ☐ Yes ☐ No
Back Pain? ☐ Yes ☐ No

Neurology
Headache? ☐ Yes ☐ No
Tingling/Numbness? ☐ Yes ☐ No
Visual Changes? ☐ Yes ☐ No
Memory Loss? ☐ Yes ☐ No
Sleep disturbances? ☐ Yes ☐ No

Psychology
Anxiety? ☐ Yes ☐ No

Smoking Status
☐ Current
☐ Former
☐ Never
☐ Vaping
Quit Year _____

Urology
Urinary frequency? ☐ Yes ☐ No
Urinary Urgency? ☐ Yes ☐ No
Blood in urine? ☐ Yes ☐ No
Urinary incontinence? ☐ Yes ☐ No
Kidney stone? ☐ Yes ☐ No

Patient Name: _____ Date:_____

Past Medical History

Do you have any of the following health conditions? If yes, please include any further information you wish to give us.

Please circle the correct response:			**COMMENTS:**
YES	NO	Hypertension	_____
YES	NO	Heart Disease	_____
YES	NO	Diabetes	_____
YES	NO	High Cholesterol	_____
YES	NO	Asthma	_____
YES	NO	Cancer	_____
YES	NO	Kidney Disease	_____
YES	NO	Liver Disease	_____
YES	NO	Thyroid Disease	_____
YES	NO	Reflux/Gastritis	_____
YES	NO	Prostate Disease	_____
YES	NO	Osteoporosis	_____
YES	NO	Anxiety	_____
YES	NO	Depression	_____
YES	NO	Sexually Transmitted Disease	_____
YES	NO	Arthritis	_____
YES	NO	Stroke	_____
YES	NO	Other	_____

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2020 HIPAA Privacy Authorization Form

NINTH STREET INTERNAL MEDICINE ASSOCIATES, INC.

Authorization for use or disclosure of protected health information. (Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)
Please list names and relationships of all persons that you authorize Ninth Street Internal Medicine Associates to release your medical information to during the course of your care:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

I hereby authorize all medical sources to release and disclose the following protected health information to:

Ninth Street Internal Medicine Associate
805 Locust Street
Philadelphia, PA 19107
Phone: 215-440-8681
Fax: 215-440-9953

Specific information to be disclosed:	The information for which I'm authorizing disclosure will be used for the following purpose:
☐ Entire Medical Record Only information related to (specify): _____	☐ Further Medical Care
☐ Only the period of events from to(please describe):_____	☐ Personal Use
☐ Other: (please describe) _____	☐ Other (please describe): _____ _____

Important Information About Your Rights

I understand that my records are protected under the Health Insurance Portability and Accountability Act, Federal Privacy Act, P.L. 93-575, the Federal Alcohol and Drug Abuse Act, P.L. 92-282, the Pennsylvania Mental Health Procedures Act, 1976 and the Pennsylvania Confidentiality of HIV Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations. Under the Mental Health Act, this authorization expires one (1) month from the date of my signature. Under the Federal Alcohol and Drug Abuse Act, this authorization shall become void ninety (90) days from the date of my signature. In addition, I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written, dated communication to the Ninth Street Internal Medicine and/or that my consent expires under the circumstance above. I understand that once copies of my information are provided, NSIM cannot prevent re-disclosure by the recipient. I understand that any information disclosed in response to this request will NOT include information related to my treatment for AIDS/HIV, psychiatric care/treatment, treatment for drug/alcohol, unless I specifically consent to release of this information by checking any or all the boxes below:

☐ AIDS/HIV Information ☐ Psychiatric Care/Treatment ☐ Treatment for Drug and Alcohol use/abuse

_____ _____
Signature of Patient Date of Birth

_____ _____
Printed Name of Patient Date of Signature

_____ (Initial) I acknowledge that I have been provided a copy of Ninth Street's Internal Medicine's Notice of Privacy Practices explaining my rights and permitted uses and disclosures with regard to my protected health information.

_____ (Initial) I acknowledge that this authorization is only good for one calendar year.

2020 HIPAA Privacy Authorization Form

NINTH STREET INTERNAL MEDICINE ASSOCIATES, LTD.

AUTHORIZATIONS
ALL PATIENTS

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or another physician's office.
I hereby authorize direct payment of medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private insurance, and any other health plan to Ninth Street Internal Medicine Associates, Ltd. I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing. I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

Signature of patient or responsible party **Date**

MEDICARE PATIENTS

I request that payment of authorized Medicare/Medigap benefits be made to me or on my behalf to Ninth Street internal Medicine Associates Ltd for any services furnished me by Ninth Street Internal Medicine Associates, Ltd.
I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of related services.

Medicare Beneficiary Signature **Date**

Medicare Number Medigap Plan

In Compliance with Medicare regulation we are required to ask the following questions:

Do you or your spouse work for a company that provides you with health benefits? ☐Yes ☐No
Are you entitled to Medicare because of disability or End Stage Renal Disease? ☐Yes ☐No
Is the illness of injury the result of an automobile accident or other injury? ☐Yes ☐No
Has treatment for the accident or illness been authorized by the Veterans Administration? ☐Yes ☐No
Are you entitled to any benefits under the Federal Black Lung Program? ☐Yes ☐No

I certify that this information is true and complete to the best of my knowledge

Signature_____ **Date**_____

NINTH STREET
INTERNAL MEDICINE ASSOCIATES, LTD.

To our patients:

We are implementing two very important elements of our electronic health record program, The *Patient Portal*, and access to the *Complete Prescription Medication History*.
The **Patient Portal** section of our electronic record will:

1. Provide you access to important elements of your medical record including:
   - Medical summaries
   - Lab results
   - Visit summaries
2. Facilitate secure email communications for non-urgent issues including:
   - Prescription refill requests
   - Referral requests
   - Appointment requests
   - Non-urgent messages to and from your care team

We will respond to these email communications within 2 business days.

PLEASE NOTE THAT URGENT MEDICAL ISSUES REQUIRING SAME DAY ATTENTION CONTINUE TO REQUIRE THAT YOU PHONE US. **In addition, if you rarely check your email please do not enable the portal.**

PATIENT PORTAL ACCESS REQUEST

I request that NSIM provide me with access to the secure Patient Portal so that I can view portions of my medical record, send, and receive non-urgent secure messages regarding my health records, laboratory tests, and appointments.

Email address: _____

_____ _____
Print Patient Name **DATE OF BIRTH**

_____ _____
Patient Signature **Date**

Complete Prescription Medication History With this tool, we will have up-to-date information about all prescriptions given to you by all of your providers. It will also help prevent adverse medication interactions. Please be assured that this is for the NSIM providers only.

CONSENT TO OBTAIN MY COMPLETE PRESCRIPTION MEDICATION HISTORY

I authorize NSIM to view my external prescription history. My signature certifies that I have read and understand the scope of my consent and that I authorize access to my prescription medication history.
If you do not wish to take advantage of this service, please check here. ☐

_____ _____ Date_____
Print Patient Name Patient Signature

_____ _____
Witness Date

CONTACT PREFERNCES

How would you prefer NSIM to contact you electronically for appointments reminders or to relay information?
CHOOSE ONE ONLY: (PLEASE CIRCLE)

HOME PHONE EMAIL TEXT MESSAGE CELL PHONE

S: Portal-RxHx-Contact