Joseph LaBricciosa, D.O.

1999 Sproul Road | Suite 21
Delaware County Medical Center
Broomall, PA. 19008
PHONE: 610.353.5840 | FAX: 855.690.0819

Patient's Name _____ DOB_____

Address (Street, apt. or unit number, city and zip code) _____

_____

Home Phone _____Cell Phone _____Work Phone _____

Email Address _____ Social Security # _____

Marital Status (please circle) single married widowed divorced

Emergency Contact: Name _____ Telephone _____

Who referred you to our office? _____

Patient's Insurance Information

Name of Policyholder (subscriber) _____ Relationship to Patient_____

Policyholder's DOB _____ Telephone _____

Address (if different from patient) _____

Name of Insurance _____ ID# _____

Do you have a secondary insurance? YES/NO Name of Secondary _____

**** IF YOUR INSURANCE PLAN REQUIRES YOU TO SELECT A PRIMARY PHYSICIAN – PLEASE CALL OUR OFFICE IF YOU NEED ANY HELP WITH THAT TASK. ****

ASSIGNMENT OF BENEFITS

I REQUES THAT PAYMENT OF AUTHORIZED MEDICARE, COMMERCIAL AND/OR SUPPLEMENTARY INSURANCE BENEFITS BE MADE ON MY BEHALF TO JOSEPH LABRICCIOSA, DO FOR AND SERVICES FURNISHED BY HIS OFFICE. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE ANY INFORMATION NECESSARY TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS ASSIGNMENT WILL BE IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS VALID AS ORGINIAL. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID OR ELIGIBLE UNDER THIS ASSIGNMENT.**

Signature of Patient or Patient's Representative _____ Date _____

Name: Date:

MEDICAL HISTORY

Gynecologic & Obstetric History

Name of physician who performed last pelvic examination:	
Age at onset of period:	Frequency:
Length of period:	Pregnancies:
Births:	Miscarriages:
Abnormal bleeding:	Abnormal discharge:
Pelvic Pain:	Abnormal PAP smear:
Birth control method:	Date of last PAP:
Mammogram:	Breast exam:

Names & Specialties of other physicians you see

Please List & Supply the Dates For the Following

Operation	Hospitalizations & Injuries
Tonsillectomy:	
Appendectomy:	
Gallbladder:	
Hysterectomy:	

Family History

Y	N	
Y	N	Anemia
Y	N	Blood disorders
Y	N	Diabetes
Y	N	High blood pressure
Y	N	Asthma
Y	N	Heart disease
Y	N	Pleurisy
Y	N	Liver disease
Y	N	Tuberculosis
Y	N	Suicide
Y	N	Cancer
Y	N	Stroke
Y	N	Epilepsy

Family History

If living | age/health ~ If deceased | age/cause of death
Mother:
Father:
Brother/Sister:
Brother/Sister:
Brother/Sister:
Brother/Sister:

Children

Sex	Age	Health

Disease & Immunization

Y	N	
Y	N	Measles immune
Y	N	Mumps immune
Y	N	Rubella immune
Y	N	Tetanus immune
Y	N	Diptheria immune
Y	N	Chicken pox immune
Y	N	Hepatitis A
Y	N	Hepatitis B
Y	N	Flu immunization
Y	N	Pneumonia immune
Y	N	TB skin test (PPD)

Prevention

Do you wear a seatbelt?	If "no", why?		
Do you wear a bike helmet?	N/A		
Do you drink coffee or tea?	Cups per day?		
Do you smoke cigarettes? cigars?	Packs per day?	Cigars per day?	
Have you ever smoked cigarettes?	Packs per day?	Years?	Year quit?
Do you drink alcoholic beverages?	Drinks per day?		Per week?
Do you exercise regularly?	Type of exercise:		
Do you have a "living will"?	Do you have a donor card?		
Have you ever worked with chemicals, paints, asbestos or other hazardous material?			
If there is a gun in your home, do you keep it unloaded and out of children's reach?			
Have you ever engaged in any activities which have put you at risk of getting AIDS?			
Do you wish to be tested for AIDS?			
Do you ever feel afraid of your partner?			
Are you in a relationship in which you've been physically abused?			

Name: Date:

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Cardiovascular

- [ ] Chest Pain
- [ ] Dizziness
- [ ] Heart attack
- [ ] Heart murmur
- [ ] High blood pressure
- [ ] Lightheadedness
- [ ] Mitral valve prolapse
- [ ] Pain in legs when walking
- [ ] Palpitations
- [ ] Rapid heartbeat
- [ ] Stroke
- [ ] Swollen feet/ankles
- [ ] Varicose Veins

Dermatologic

- [ ] Changing mole(s)
- [ ] Fungal nail infection
- [ ] Hives/Eczema
- [ ] Itchy skin
- [ ] Itchy skin
- [ ] Rashes
- [ ] Skin ulcers
- [ ]
- [ ]

Ear, Nose & Throat

- [ ] Bleeding gums
- [ ] Ear Pain
- [ ] Frequent nose bleeds
- [ ] Headaches
- [ ] Hearing loss
- [ ] Hoarseness
- [ ] Nasal congestion
- [ ] Ringing in ears
- [ ] Runny nose
- [ ] Seasonal allergies/hay fever
- [ ] Sinus congestion
- [ ] Sore throat
- [ ] Sore/ulcer in mouth
- [ ] Tooth pain
- [ ]
- [ ]

Other

- [ ] Anorexia
- [ ] Blurred vision
- [ ] Bright painful light
- [ ] Cataracts
- [ ] Chills
- [ ] Eye drainage
- [ ] Eye pain
- [ ] Fatigue
- [ ] Fever
- [ ] Night sweats
- [ ] Weight gain
- [ ] Weight loss
- [ ]
- [ ]

Endocrine

- [ ] Excessive hair growth
- [ ] Excessive hunger
- [ ] Excessive thirst
- [ ] Hair loss
- [ ] Heat/cold intolerance
- [ ] Hot flashes
- [ ] Hypoglycemia
- [ ] Increased skin pigmentation
- [ ] Thyroid disease

Hematology/Oncology

- [ ] Anemia
- [ ] Blood disorders
- [ ] Cancer
- [ ] Easy bruising
- [ ] Excessive bleeding
- [ ] Hepatitis/jaundice
- [ ] Swollen lymph glads

Gastrointestinal

- [ ] Abdominal pain
- [ ] Bloating
- [ ] Bloody stool
- [ ] Change in bowels
- [ ] Colitis
- [ ] Constipation
- [ ] Diarrhea
- [ ] Difficulty swallowing
- [ ] Heartburn
- [ ] Hemorrhoids
- [ ] Loss of appetite
- [ ] Nausea
- [ ] Vomiting

Musculoskeletal

- [ ] Arthritis
- [ ] Back pain
- [ ] Bursitis
- [ ] Gout
- [ ] Joint pain
- [ ] Muscle pain

Neurologic

- [ ] Epilepsy/seizures
- [ ] Fainting
- [ ] Faintint spells
- [ ] Headaches
- [ ] Memory loss
- [ ] Tremor
- [ ] Vertigo (spinning sensation)
- [ ] Weakness

Psychiatric

- [ ] Alcohol abuse
- [ ] Anxiety
- [ ] Crying spells
- [ ] Depression
- [ ] Drug abuse
- [ ] Feeling stressed
- [ ] Mood swings
- [ ] PMS/pre-menstrual tension
- [ ] Poor concentration
- [ ] Suicidal thoughts

Urinary/GU

- [ ] Blood in urine
- [ ] Excessive nighttime urination
- [ ] Frequent urination
- [ ] Kidney stones
- [ ] Painful Intercourse
- [ ] Painful Menstruation
- [ ] Painful Urination
- [ ] Urgency

Pulmonary

- [ ] Cough
- [ ] Coughing up blood
- [ ] Shortness of breath
- [ ] Wake w/shortness of breath
- [ ] Wheezing
- [ ]
- [ ]

MEDICATIONS

Name	Dose	How often taken

MEDICATIONAL ALLERGIES

Name	Type of reaction

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize:

Previous Physician: _____

Address: _____

_____

Telephone#: _____

Fax#: _____

To release a copy of my medical record to:

Joseph LaBricciosa, D.O.

1999 Sproul Road | Suite 21
Delaware County Medical Center
Broomall, PA. 19008

PHONE: 610.353.5840 | FAX: 855.690.0819

Permission is granted to include:

All Health Records ____ Mental Health Records _____ Drug & Alcohol Records _____ HIV Records ___

Patients Name: _____ DOB: _____

Address: _____

_____

The pages accompanying this fax transmission contain Information from the above physician. This information which may be confidential and privileged is intended for the use of the individual or entity named on this cover sheet. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the contents of the information is prohibited. If you have received this fax in error, please notify us by telephone so that we may arrange for the retrieval of the original document.

Signature: _____ Date: _____

Joseph LaBricciosa, D.O.

1999 Sproul Road | Suite 21
Delaware County Medical Center
Broomall, PA. 19008

PHONE: 610.353.5840 | FAX: 855.690.0819

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

1. The right to inspect and copy your information with notice.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosure of information.
6. The right to a paper copy of this notice.

We want to assure you that your medical/protected health information is secure with us. This notice contains information about how we will ensure that your information remains private. If you have any questions about this notice, please contact the office at 610.353.5840

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

"I hereby acknowledge that I have received/been offered a copy of this practices NOTICE OF PRIVACY PRACTICES. I understand that if I have any questions or complaints regarding my privacy rights that I may contact the office listed above. I further understand that the practice will offer updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified or changed in any way."

(Please Print) Patient or Patient's Representatives Name_____
Signature of Patient or Patient's Representatives Name_____
Date_____ Patient Refused_____ Patient was unable to sign because_____

HIPAA AUTHORIZATION FORM FOR USE OR DISCLOSURE Of HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1196 (HIPAA) Privacy Standards.

Patient's Name: _____ Date of Birth: _____

Release of Information

I Authorize the office of Dr. LaBricciosa to use and disclose the following health information:

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

_____

☐ - My health information covering the period from _____ (date) to _____ (date)

☐ - Information is NOT to be released to anyone

The above party may disclose this health information to the following recipients:

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

I Understand that I have the right to revoke this authorization, in writing, at any time. This ***Release of Information*** will remain in effect until terminated by me in writing.

Print Name: _____

Signature: _____

Date: _____

Joseph LaBricciosa's, D.O.
Family Practice
1999 Sproul Road, Suite 21 Broomall, PA 19008
P: 610-353-5840 | F: 855-690-0819
www.drjosephlabricciosa.com

- **I have evening hours on Monday and Thursday nights.**

Most physicians only have one set of evening hours. I have evening appointments on both Monday and Thursday nights from 5:00PM to 7:45PM normally. This is to help make sure that there will be a convenient time for you to take care of your healthcare needs.

- **I am not in the office on Wednesdays.**

No, this is not because I am out golfing. I make rounds at nursing homes throughout the community on Wednesdays, so I will not be able to schedule appointments for that day. Keep this in mind so that you can take care of any questions/appointments by the end of Tuesday, especially if you are afraid the issue cannot wait until Thursday. Of course, if you have an urgent issue that arises on Wednesday, you can get help by calling the office.

- **Please be prepared to come to the office if you are ill.**

I cannot always treat patients accurately over the phone. It is not good medical practice because I may need to do an examination to see what is wrong with you. Serious warning signs or hints to your diagnosis may be missed without and examination.

- **Please tell me your side effects.**

Let me know if a medication that I prescribed is giving you a side effect. If your medicine is bothering you, it is possible for us to find a substitute that is easier on your body. I can also make a note of your reaction in your chart so that medication can be avoided in the future.

- **Please fill any prescriptions and go for any tests that I order.**

Once I give you a script, it is your responsibility to fill the prescription or go for the tests ordered. If I give you a script which you know you do not want to fill or are not able to fill, or a test you won't get, please let me know so that we can work something out.

- **My pet peeve:**

I am in the office a lot of hours, so time with my family is limited and very important to me. If you feel like you are getting ill, please come in for an appointment or call me during regular office hours. All calls outside of normal business hours should be limited to emergencies. Routine medication will not be refilled on weekends.

- **After hours care:**

Please feel free to use any of the closest urgent care centers at nights, weekends or Wednesdays if you need to be seen. These various centers do a good job of sending me a report of your visit.

Patient Signature_____Date_____

JOSEPH LaBRICCIOSA, D.O.

1999 Sproul Road
SUITE 21
BROOMALL, PA 19008-3504
(610) 353-5840
FAX (855) 690-0819

AGREEMENT AS RESOLUTION OF CONCERN

Please Read Carefully

I understand that I am entering into a contractual relationship with Dr. Joseph LaBricciosa for medical care. I further understand that meritless and frivolous claims for medical malpractice ha'i/e an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to medical providers. As additional consideration for professional care provided to me by Dr. LaBricciosa, I, the patient and/or r:ny representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Dr. LaBricciosa.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I and/or my representatives agree to use American Board of Medical Specialties ("ABMS") board certified expert medical witnesses in the same specialty as Dr. LaBricciosa, Family Practice. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined by expert witnesses by the PA Medical Society.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions..

Dr. LaBricciosa agrees to same stipulations as presented above.

Joseph LaBricciosa DO

Physician

Patient/Guardian

Effective from Date of Treatment:

Date of Signature

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐