JEFFREY S. FREEMAN, DO FACOI

ENDOCRINOLOGY, METABOLISM AND DIABETES

1569 Medical Drive
Pottstown, PA 19464

4190 City Line Ave., Suite 324
Philadelphia, PA 19131

2705 Dekalb Pike, Suite 309
Norristown, PA 19401

Patient's Name _____

Patient's Date of Birth _____

Allergies _____

Medication List

Medication	Dosage	Indication

Jeffrey S. Freeman D.O. F.A.C.O.I.

PATIENT INFORMATION

Date_____ ( )New ( ) Revision

Referring Physician:_____Phone #:_____

Primary Care Physician:_____Phone#:_____

Patient Name:_____
(LAST) (FIRST) (M) (Title)

Date of Birth:_____Gender:_____Marital Status:_____

Social Security #:_____Home Phone:_____

Cell Phone:_____Business Phone:_____

Daytime or Evening Phone, If Different:_____

Street Address:_____

_____
(City) (State) (Zip Code)

Employer:_____Occupation:_____

Business Address:_____

Business Address Cont._____

_____

Person to Contact In Case of Emergency:_____

Emergency Contact Address and Telephone #:_____

Person Responsible for Account:_____
(Last) (First)

Address and Telephone #:_____

Relationship to Patient:_____Birthdate:_____SSN:_____

_____

Insurance Company:_____

Insurance Address:_____

Subscriber ID#:_____Group #:_____

Secondary Insurance Company:_____

Secondary Insurance Address:_____

Secondary Ins ID#:_____Group #:_____

Pharmacy Name and Phone No.:_____

Medicare Beneficiary Authorizations

Name of Beneficiary _____ Health Insurance Claim # _____

"I request that payment of authorized Medicare benefits be made to either me or on my behalf to Jeffrey S. Freeman, D.O. and/or supplier for any services furnished to me by that provider of services and/or supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service."

Beneficiary Signature _____ Date _____

MEDIGAP (Medicare Patients Only)

Name of Beneficiary _____ Health Insurance Claim # _____

Medigap Policy # _____

"I request that payment of authorized Medigap benefit be made to me or on my behalf to Jeffrey S. Freeman, D.O. and/or supplier for any services furnished to me by that provider for service and/or supplier. I authorize any holder of Medicare information about me to release to:_____any information needed to determine these benefits payable for related services."

Beneficiary Signature _____ Date _____

Jeffrey S. Freeman D.O. FACOI

Patient History and Review of Systems (18 years and older)

Name:_____ DOB:_____

If Thyroid Problem:

History of Thyroid cancer Yes No
History if Radiation to face or neck (beyond routine x-rays) Yes No

If Diabetes Problem:

Do you pass water during the night? Yes No
Tingling of hands or feet Yes No
Last eye exam Date_____
Last foot exam Date_____

Allergies:_____

Check if you have the following:

GENERAL
___Fever
___Chills
___Sweats
___Anorexia
___Fatigue
___Weakness
___Malaise
___Weight Loss
___Sleep Disorder

EYES
___Vision Loss - 1 Eye
___Double Vision
___Eye Irritation
___Vision Loss- Both Eyes
___Blurring
___Eye Pain
___Halos
___Eye Discharge
___Light Sensitivity

EARS, NOSE AND THROAT
___Ringing in Ears
___Ear Discharge
___Earache
___Decreased Hearing
___Nasal Congestion
___Nosebleeds
___Difficulty Swallowing
___Hoarseness
___Sore Throat

CARDIOVASCULAR
___Difficult Breathing at Night

GASTROINTESTINAL
___Excessive Appetite
___Loss of Appetite
___Indigestion
___Vomiting Blood
___Nausea
___Vomiting
___Yellow Skin Color
___Gas
___Abdominal Pain
___Abdominal Bloating
___Hemorrhoids
___Diarrhea
___Change in Bowel Habits
___Constipation
___Dark Tarry Stools
___Blood in the Stools

GENITOURINARY
___Foul Urinary Discharge
___Blood in the Urine
___Urinary Frequency
___Inability to Empty Bladder
___Urinary Urgency
___Kidney Pain
___Trouble Starting Stream
___Painful Urination
___Nighttime Urination
___Inability to Control Bladder
___Genital Sores
___Lack of Sexual Drive
___Erectile Dysfunction
___Excessively Heavy Periods
___Missed Periods

NEUROLOGICAL
___Diff. With Concentration
___Poor Balance
___Headaches
___Coordination Difficulty
___Numbness
___Inability to Speak
___Falling Down
___Tingling
___Brief Paralysis
___Visual Disturbances
___Seizures
___Weakness
___Sensation of Room Spinning
___Tremors
___Fainting
___Excessive Daytime Sleepiness
___Memory Loss

PSYCHOLOGICAL
___Sense of Great Danger
___Anxiety
___Thoughts of Suicide
___Mental Problems
___Depression
___Thoughts of Violence
___Frightening Visions/Sounds

ENDOCRINE
___Excessive Hunger
___Cold Intolerance
___Heat Intolerance
___Excessive Urination
___Excessive Thirst
___Weight Change

JEFFREY S. FREEMAN, D.O. FACOI

Check if you have the following:

___Near Fainting
___Chest Pain or Discomfort
___Racing/Skipping Heart Beats
___Fatigue
___Lightheadedness
___Shortness of Breath with Exertion
___Palpitations
___Swelling of Hands or Feet
___Difficulty Breathing Lying Down
___Fainting
___Leg Cramps with Exertion
___Bluish Color Lips and Nails
___Weight Gain
___Loss of Strength

RESPIRATORY

___Breathing Disturbs Sleep
___Cough
___Shortness of Breath
___Coughing Up Blood
___Chest Discomfort
___Wheezing
___Excessive Sputum
___Excessive Snoring

___Unusual Urinary Color
___Abnormal Vaginal Bleeding
___Pelvic Pain

MUSCULOSKELETAL

___Muscle Cramps
___Joint Pain
___Joint Swelling
___Joint Fluid Present
___Back Pain
___Stiffness
___Muscle Weakness
___Arthritis
___Gout
___Muscle Aches

DERMATOLOGICAL

___Excessive Perspiration
___Night Sweats
___Suspicious Lesions
___Changes in Nail Beds
___Poor Wound Healing
___Dryness
___Unusual Hair Distribution
___Skin Cancer
___Itching
___Changes in Skin Color
___Flushing
___Rash

HEMATOLOGY

___Enlarged Lymph Nodes
___Bleeding
___Skin Discoloration
___Abnormal Bruising
___Fevers

ALLERGY

___Persistent Infections
___Hives or Rash
___Seasonal Allergies
___HIV Exposure

BREAST

___Right Breast Lump
___Lest Breast Lump
___Nipple Discharge
___Bloody Discharge from Nipple
___Breast Pain
___Abnormal Mammogram
___Breast Enlargement

FAMILY HISTORY: **WHO:**

Cancer_____

Diabetes_____

Heart Disease_____

High Cholesterol_____

Osteoporosis_____

Coronary Heart Disease-Male<55_____

Coronary Heart Disease-Female<65_____

Thyroid Disease_____

RISK FACTORS:

Ever Smoked? ___Yes ___No

Packs per day_____

Year Started_____

Date Quit_____

Drug Use: ___Yes ___No

Alcohol Use: ___Yes ___No

Number of drinks per day_____

Exercise:

Frequency/Week_____

Type_____

Signature_____

Date_____

HIPPA Notice of Privacy Practices

Jeffrey S. Freeman, DO FACOI
4190 City Avenue
Suite 324
Philadelphia, PA 19131
(215) 871-1916

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____ Date_____