

**Kenneth Sharp, DO**  
Board Certified Family Medicine



525 Iron St Suite B  
Lehigh, PA 18235  
Phone (610) 377-4181  
Fax (610) 377-4185

**NEW PATIENT MEDICAL HISTORY AND QUESTIONNAIRE**

*The information on this form is part of your confidential medical record. Please be honest with your responses. Please be advised that, for identification and part of your medical record, your photograph will be taken during your first visit.*

Name: \_\_\_\_\_ Male / Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
**EMAIL ADDRESS:** \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby  DO or  DO NOT give permission to leave messages on my answering machine regarding appointment reminders, results of blood work, or results of other studies.

I hereby  DO or  DO NOT give permission to receive email regarding appointment reminders, results of blood work, or results of other studies.

I hereby give permission to Lehigh Family Medicine to discuss my medical issues, lab results, or any other matters related to my health with ONLY the following persons: (maximum of two)

1. \_\_\_\_\_  2. \_\_\_\_\_

**None.** I expressly want my medical issues to remain completely private and not discussed with any family members.

**EMPLOYER (or NAME OF SCHOOL):**

Employer: \_\_\_\_\_  
Location: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

**ADDITIONAL HOUSEHOLD MEMBERS:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_

**PREVIOUS PHYSICIAN or MEDICAL GROUP:** \_\_\_\_\_

How did you find us:  Previous Patient  Phone Book  Internet  Friend: \_\_\_\_\_

**PREFERRED LOCAL PHARMACY:** \_\_\_\_\_ City: \_\_\_\_\_

For long term medication, I prefer to use a mail order pharmacy:

**MAIL ORDER PHARMACY:** \_\_\_\_\_ FAX #: \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Insurance Co: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Other:  Self Pay (no insurance)  Workman's Compensation

**MEDICAL HISTORY:** (Please check *only those that apply to YOU.*)

**NOW PAST Unsure**

- High Blood Pressure
- Diabetes (without insulin)
- Diabetes (with insulin)
- High Cholesterol
- Obesity

**NOW PAST Unsure**

- Esophageal reflux (GERD)
- Stomach ulcer
- Jaundice or liver disease
- Crohn's or Colitis
- Diverticular disease

- Heart Attack
- Heart Valve Disease
- Palpitations
- Congestive Heart Failure (CHF)
- Chronic chest pain

- Kidney disease
- Skin disease
- Thyroid problems
- Difficulty urinating
- Bleeding problems

- Asthma
- COPD / Emphysema
- History of pneumonia
- History of tuberculosis
- Chronic cough

- Arthritis
- Chronic back pain
- Chronic infections
- Anemia
- Gout

- Epilepsy / Seizures
- Stroke or TIA
- Migraines / Headaches
- Anorexia or bulimia
- Dizziness

- Alcohol abuse
- Substance abuse
- Depression
- Anxiety disorder
- Bipolar disorder

**PAST SURGICAL HISTORY:      YEAR OF SURGERY:**

- Ear tube placement ..... \_\_\_\_\_
- Tonsillectomy & Adenoidectomy..... \_\_\_\_\_
- Appendectomy ..... \_\_\_\_\_
- Gall bladder removal ..... \_\_\_\_\_
- Hysterectomy ..... \_\_\_\_\_
- Mastectomy of Left or Right breast... \_\_\_\_\_
- Nephrectomy of Left or Right kidney. \_\_\_\_\_
- Prostatectomy ..... \_\_\_\_\_
- Coronary Angioplasty ..... \_\_\_\_\_
- Coronary Artery Stent Placement ..... \_\_\_\_\_
- Coronary Artery Bypass ..... \_\_\_\_\_
- Other surgery: ..... \_\_\_\_\_
- Other surgery: ..... \_\_\_\_\_

**PAST CANCER HISTORY:**

- No known history of any cancer
- Cancer of: \_\_\_\_\_ year: \_\_\_\_\_
  - History of chemotherapy
  - History of radiation therapy
  - Cured or in remission
  - Continuing with treatment at this time
- Cancer of: \_\_\_\_\_ year: \_\_\_\_\_
  - History of chemotherapy
  - History of radiation therapy
  - Cured or in remission
  - Continuing with treatment at this time
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

**SOCIAL HISTORY:**

Marital status: Single Married Divorced Widowed Under age of 17, living with parent/guardian  
Living situation: Living alone Living with spouse Living with children #\_\_\_ other: \_\_\_\_\_  
Tobacco use: Never smoked Former smoker, quit \_\_\_ years ago Currently smoking for \_\_\_ total years  
Alcohol use: None Socially Frequently: \_\_\_ drinks/beers per day In active recovery  
Recreational drug use: None Former user of... Active user of... Marijuana Cocaine Opiates

**FAMILY MEDICAL HISTORY:**

Mother Living, age \_\_\_ Deceased at age \_\_\_ due to: \_\_\_\_\_  
History of: Hypertension Diabetes Heart disease Other: \_\_\_\_\_ Cancer: \_\_\_\_\_  
Father Living, age \_\_\_ Deceased at age \_\_\_ due to: \_\_\_\_\_  
History of: Hypertension Diabetes Heart disease Other: \_\_\_\_\_ Cancer: \_\_\_\_\_  
Siblings: None #\_\_\_ brothers, #\_\_\_ sisters  
History of: Hypertension Diabetes Heart disease Other: \_\_\_\_\_ Cancer: \_\_\_\_\_  
Other family history: \_\_\_\_\_





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**Kenneth Sharp, DO**  
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 525 Iron St Suite B  
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 Fax: (610) 377-4185

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

|                                |                                    |
|--------------------------------|------------------------------------|
| _____<br>Patient's full name   | _____<br>Date of Birth (Mo/Day/Yr) |
| _____<br>Street Address        | _____<br>Social Security Number    |
| _____<br>City, State, Zip Code | _____<br>Home Phone                |

At the request of the individual above, Lehigh Family Medicine, LLC, Kenneth Sharp, DO, hereby authorizes

\_\_\_\_\_  
Name of Practice or Health Care Provider

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Health Care Provider Phone

\_\_\_\_\_  
Health Care Provider Fax

to release the following medical records:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Lab Reports       | <input type="checkbox"/> Complete Record  | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Progress Notes       | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Most Recent Note |  |
| <input type="checkbox"/> Operative Notes      | <input type="checkbox"/> Hospital Records  | <input type="checkbox"/> Other _____      |  |

**INFORMATION RELEASE TO: Lehigh Family Medicine, LLC**  
**Kenneth Sharp, DO**  
 525 Iron St Suite B  
 Lehigh, PA 18235

**(610) 377- 4181 (Phone)**  
**(610) 377- 4185 (Fax)**

**PURPOSE OF DISCLOSURE:**

- Establish care     Continuity of Care     Other \_\_\_\_\_

*I understand that:*

- I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at Lehigh Family Medicine (LFM) unless (a) the only purpose of the treatment is to create health information for the disclosure listed above; or (b) if my treatment is related to participation in a research study for which this authorization is required.
- I may revoke this authorization at any time by submitting a written notice of revocation to LFM at the address listed above. The revocation will be effective upon LFM's receipt of my written notice, except that it will not have any effect on any action already taken by LFM in reliance on this authorization.
- Once LFM has disclosed my health information to the recipient, LFM cannot guarantee that the recipient will not re-disclose my health information to a third party.

**This authorization**     will automatically expire 90 days or     has no expiration date (please check one).

\_\_\_\_\_  
Signature of Patient, Guardian or Personal Representative    Date \_\_\_\_\_

\_\_\_\_\_  
Practice Representative/Witness    Date \_\_\_\_\_

## Lehigh Family Medicine, LLC

### NOTICE OF PRIVACY PRACTICES

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

**Lehigh Family Medicine, LLC (LFM)** is required by law to maintain the privacy of patients' personal health information and to provide patients with notice of LFM legal duties and privacy practices with respect to your personal health information. LFM is required to abide by the terms of the *Notice of Privacy Practices* as necessary and make the new Notice effective for all personal health information maintained by LFM. You may receive a copy of any revised notices by mailing a request to Privacy Officer, Lehigh Family Medicine, LLC, 525 Iron St Suite B, Lehigh, Pa 18235.

### **USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION**

**Your Authorization:** Except as outlined below, LFM will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the disclosure. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

**Uses and Disclosures for Treatment:** LFM will make uses and disclosures for your personal health information as necessary for your treatment. For instance, doctors, nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, etc. LFM may also release your personal health information to another health care facility or professional who is or will be providing treatment to you. For instance, if you are going to receive home care or are being referred to a specialist for treatment, LFM may release your personal health information to that facility so that a plan of treatment can be prepared for you.

**Uses and Disclosure for Payment:** LFM will make uses and disclosures of your personal health information as necessary for payment purposes of those health professionals and facilities that have treated you or provided services to you. For instance, LFM may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you, or LFM may use your information to prepare a bill to send to you or the person responsible for your payment.

**Family and Friends Involved in Your Care:** LFM may, from time to time, disclose your personal health information to family, friends and others who are involved in your care or in payment of your care. If you are unavailable, incapacitated, or facing an emergency medical situation and it is determined that a limited disclosure may be in your best interest, limited personal health information may be shared with such individuals without your approval.

**Appointments and Services:** LFM may contact you to provide appointment reminders or test results. You have the right to request, and LFM will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, you may wish appointment reminders not to be left on voice mail or sent to a particular address. You may request such confidential communication in writing. Request forms may be obtained from registration at our office.

**Health Products and Services:** LFM may from time to time use your personal health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services offered by LFM and to provide general health and wellness information.

(continued)

**Other Uses and Disclosures:** Federal laws and regulations do not protect any information about suspected child or elder abuse or neglect from being reported under Pennsylvania State Law to appropriate State or Local authorities. LFM is permitted or required by law to make certain other uses and disclosure of your personal health information without your consent or authorization. These include:

- For any purpose required by law; for public health activities, such as required reporting of disease, injury, birth, death, and for required public health investigations.
- For suspected child/elder abuse or neglect; or if there is suspicion that you may be a victim of abuse, neglect or domestic violence.
- To the FDA to report adverse events, product defects, or to participate in product recalls.
- To your employer when LFM has provided health care to you at the request of your employer to determine workplace-related illness or injury.
- To coroners and/or funeral directors consistent with local, state, and federal laws.
- If necessary to arrange an organ or tissue donation from you or a transplant for you.
- If you are a member of the military as required by armed forces services; or if necessary for national security or intelligence activities. LFM may release your personal health information in accordance with any state laws that are more restrictive of limiting than Federal privacy regulations. (Pennsylvania law requires that we obtain a consent form from you before disclosing the performance or results of an HIV test or diagnosis of AIDS or AIDS-related condition.)

## **RIGHTS THAT YOU HAVE**

**Access to Your Personal Health Information:** You have the right to inspect and/or copy much of the personal health information that LFM retains on your behalf.

**Amendments to Your Personal Health Information:** You have the right to request in writing that personal health information maintained by LFM be amended or corrected. LFM is not obligated to make all requested amendments but will give each request careful consideration.

**Accounting for Disclosures of Your Personal Health Information:** You have the right to receive an accounting of certain disclosures made by LFM of your personal health information after April 14, 2003. The first accounting is free; you will then be charged a fee of \$5.00 for each subsequent accounting.

**Restrictions on use and disclosure of Your Personal Health Information:** You have the right to request restrictions on certain of LFM uses and disclosures of personal health information for treatment, payment, or health care operations. LFM is not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate.

**All requests for Access, Amendments, Accounting for disclosures,  
and Restrictions on Use and Disclosure must be in writing  
and signed by you or your representative.  
Forms can be obtained from a LFM receptionist.**

## **RECORDS**

Charts that have been inactive for 10 years are destroyed except for the charts of children, which are kept until the child is 18 years old.

## **QUESTIONS AND COMPLAINTS**

If you have questions regarding this *Notice of Privacy Practices*, you may call (610) 377-4181. If you believe your privacy rights have been violated, you can file a complaint with the LFM Privacy Officer by mail or by telephone. Please direct correspondence to Kenneth Sharp, DO, Lehigh Family Medicine, LLC, 525 Iron St, Suite B, Lehigh, Pa 18235. You may also file a complaint with Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights.

# Lehigh Family Medicine, LLC

525 Iron St Suite B  
Lehigh, Pa 18235

## FINANCIAL POLICY

In Order to provide your health care at the most affordable cost,  
our medical staff requires payment at the time of service.

### OUR BILLING SERVICE:

Our billing and collections are handled very professionally by *Physicians Group Management*, a very experienced and highly professional medical billing company located in northern New Jersey.

### IF YOU HAVE INSURANCE:

We will file a claim with your insurance company, but *you are responsible for any balances*. If you have health insurance, you will not be held liable for "insurance charges" until 30 days after the date of service. If, after 30 days, your insurance has not paid in full, the entire balance becomes your responsibility. Insurance co-payments and deductibles are due at the time of the service.

### SELF PAY:

If you are without health insurance, our staff will require payment for the office call at the time of service. Additional services will be billed to you. If full payment cannot be made within 30 days, our staff will be happy to arrange a repayment agreement.

### OUR COLLECTIONS POLICY:

If, after 30 days from the date of service, your account is not paid in full, all charges are your responsibility. If, after 60 days from date of service, a balance still remains, we have the option of forwarding your account to our collections department. If, after 90 days from the date of service, any balance remains on your account, we will consider an outside collection agency or other means to pursue your account. To avoid this, please call our business office to make special arrangements regarding a payment agreement.

### DELINQUENT ACCOUNTS:

After 120 days, if a balance remains without a payment agreement, we will no longer continue as your family's provider of health care. We suggest that you place yourself under the care of another physician without delay. Once paid, in full, we will be happy to consider reinstating the patient/doctor relationship. However, future services may be based upon a "cash only" agreement, as determined by Lehigh Family Medicine, LLC.

**My signature below indicates that I have read and understand the terms of this financial policy.**

**PATIENT'S NAME** \_\_\_\_\_  
*Printed Name of Patient*

**RESPONSIBLE PARTY** \_\_\_\_\_  
*Signature of Responsible Party*

**RESPONSIBLE PARTY** \_\_\_\_\_  
*Printed Name of Responsible Party*

**DATE** \_\_\_\_\_

**WITNESS** \_\_\_\_\_  
*Representative of Lehigh Family Medicine*

**Lehigh Family Medicine, LLC**  
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## **Acknowledgement of Privacy Practices**

Patient Name: \_\_\_\_\_  
*Print Name*

I have received a copy of the Lehigh Family Medicine, LLC "Notice of Privacy Practices" on: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Month Day Year*

Phone numbers are listed on the "Notice of Privacy Practices" should I have any questions. I understand a copy of this notice is available for viewing at any time at [www.LehighFamilyMed.com](http://www.LehighFamilyMed.com)

Signature: \_\_\_\_\_  
*Signature of Patient or Legal Representative/Witness*

Print Name: \_\_\_\_\_  
*Legal Representative (if different from patient include relationship)*