LVPG ENDOCRINOLOGY

Providers

Donald Barilla, MD, FACP	***Robert A. McCauley, MD***	***Donna M. Gilbert, CRNP***
Andrew Brackbill, MD	***Vasudev Magaji, MD***	***Debra McGeehin, CRNP***
Robert B. Doll, MD	***Gretchen Perilli, MD, FACE***	***Constance Molchany, CRNP***
Mal Homan, MD	***Sharmila Subaran, MD***	***Cynthia Payonk, CRNP, CDE***
Ya-Yu (Dan) Lee, MD	***Marc A. Vengrove, DO, FACP***	***Kathleen Post, CRNP***

Practice Locations

1243 S. Cedar Crest Blvd., Suite 2800
Allentown, PA 18103
610-402-6790 phone
610-402-6979 fax

2663 Schoenersville Rd.
Bethlehem, PA 18017
484-895-4440 phone
484-895-4450 fax

Health Center at Quakertown
99 N. West End Blvd., Suite 105
Quakertown, PA 18951
215-538-7193 phone

Appointment Date _____Time_____

Welcome to our practice. To partner with you to provide quality healthcare, here are some key points to better acquaint you with our practice and to provide you with an optimum visit.

Check List for items to bring with you

- ☐ Attached forms completed.
- ☐ Insurance Card(s)
- ☐ Insurance referral if required by your insurance
- ☐ Photo ID (i.e. driver's license, passport, state ID)
- ☐ Current list of medications, doses, and frequency.
- ☐ Co-payment if required by your insurance- cash, personal check, Master Card, VISA, Discover, American Express and most flex spend cards are accepted.

Let's make your visit the best it can be!

- FREE parking at all locations, including the parking deck at the Allentown location.
- If there are any changes to your insurance, please call us as soon as possible so we can check if we participate with your new insurance.
- Contact your family doctor at least three (3) days prior to your appointment for an insurance referral if your insurance requires one.
- Can't keep your appointment? Please call our office as soon as possible to reschedule or cancel your appointment. It may be necessary to reschedule your appointment if you arrive more than 10 minutes late.
- Normal office hours are Monday through Friday, 8:00 A.M. to 5:00 P.M

What to expect at the time of your visit?

1. Upon arrival please check in with the receptionist at the front desk before taking a seat.
2. The nursing staff will bring you to an exam room and the information you provide on the attached forms will be reviewed.
3. Your doctor or nurse practitioner will then see you to review your information and discuss the reason for your visit.
4. There will not be any labs drawn at the time of your visit.

Thank you for choosing LVPG Endocrinology for your health care needs.
We look forward to partnering in your care!

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

PLEASE RETURN THIS FORM TO THE RECEPTIONIST
PATIENT INFORMATION

LAST NAME_____FIRST NAME_____MI_____

ADDRESS _____

CITY_____STATE_____ZIP_____EMAIL _____

HOME PHONE_____OTHER PHONE_____☐MALE ☐ FEMALE

DATE OF BIRTH_____ MARITAL STATUS _____ SS#_____

INSURANCE	PRIMARY	SECONDARY
NAME	_____	_____
GROUP #	_____	_____
SUBSCRIBER	_____	_____
EFFECTIVE DATE	_____	_____

REFERRING DOCTOR INFORMATION

FAMILY DOCTOR_____PHONE NUMBER_____

REFERRING DOCTOR_____PHONE NUMBER_____

EMPLOYER INFORMATION

PATIENT EMPLOYER_____OCCUPATION_____

EMPLOYER ADDRESS_____PHONE NUMBER_____

SPOUSE INFORMATION

LAST NAME_____FIRST NAME_____MI_____

DATE OF BIRTH_____ SS#_____WORK NUMBER_____

EMPLOYER_____EMPLOYER ADDRESS_____

EMERGENCY CONTACT

NAME_____PHONE NUMBER_____ _____

RELATIONSHIP_____ NEXT OF KIN_____

IF PATIENT IS A MINOR

MOTHER'S NAME_____SS#_____DATE OF BIRTH_____

FATHER'S NAME_____SS#_____DATE OF BIRTH_____

LVPG Medical Information Communication Preferences

Patient _____ MR#_____ DOB ____/___/____

As our patient, we may need to reach you when you are not in the practice. For your privacy, please indicate your preferred method for us to communicate confidential medical information, such as test or lab results, to you and/or others involved in your care. Please note that "appointment reminder telephone calls" may be left at the contact number(s) you list below. Please list your email address to receive online health care educational programs ordered by your care provider.

PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:

❑ I give permission to **leave medical information** pertaining **to me, my dependent or child**, at the numbers listed below:

Method	Yes	No	Area Code, Phone #, Ext, E-MAIL
Home telephone			
Answering Machine			
Work Phone			
Cell Phone			
E-MAIL for our MYLVHN secure email registration			

Without specific permission, we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.):

❑ Do **not release medical information** to anyone other than myself.

❑ I give **permission to release medical information** pertaining to me to the individuals listed below.

Name	Relationship (i.e. spouse, parent, son, daughter, etc.)	Area Code, Phone # - Extension

Comments

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____(Please Print Signer's Name)