Marc Kress, M.D. & Associates

FAMILY PRACTICE

610 Old York Road
Suite 70
Jenkintown, PA 19046
(215) 887-3100

Dear New Patient:

WELCOME TO OUR PRACTICE! We are looking forward to your first visit with us and would like to get you acquainted with our practice before we see you. Enclosed is a patient information form that will save time if you fill it out ahead of time. Please bring your insurance card and a form of photo ID to your first appointment.

We are proud to be one of the longest-standing, privately-owned Family Practices in the Abington/Jenkintown area. We believe that our independence helps to assure the high quality of personalized care that we provide to each and every patient. You play an important role in this quality of care and, with this role, comes a few responsibilities. We ask that all of our patients communicate as thoroughly as possible with our doctors and staff so that we can understand how best to care for you. We also ask that our patients respect the policies we have in place so that all of our patients can be served in the most efficient manner possible. (Some of those policies are outlined in our website kressfamilypractice.com and include things like keeping your appointments, arriving on-time, paying your copay and bills on time, and giving us adequate notice for refills and HMO referrals.)

Please note that our office shares the street address of Jenkins Court, the former home of Strawbridge and Clothier and the home of the Outback Steakhouse, but we are on top of the parking garage on the north side of the building and *not in the main building* itself. Our GPS address is 670 Old York Road, Jenkintown, which might be helpful. Just drive out onto the top level of the parking garage and you will see the little strip of offices along the back. If using public transportation, there is a bus stop right out front on York Road and two sets of stairs leading from the lower level of the garage to the upper level.

Again, welcome, and we look forward to a long and healthy relationship with you and your family.

Sincerely,

Drs. Kress, Altobelli, Ukwu & Lewcun

SUITE 70

Social History Questionnaire

1. Marital History	Single	Married	Divorced	Separated	Widowed	Domestic Partner
2. Lives with						
3. Pets	None	Dog	Cat	Other:		
4. Smoke alarm in house	Yes	No				
5. Carbon Monoxide Detector	Yes	No				
6. Guns in home	No	Yes, locked	Yes, unlocked			
7. Education	Highest level completed:					
8. Occupation						
9. Work Status	Employed Full time	Employed Part time	Retired	Unemployed	Disabled	
10. Diet	Vegetarian	Vegan	Flexitarian	Paleo	Keto	Other:
11. Sleep	Average hrs per night:	Problems falling asleep	Problems staying asleep			
12. Issues with	Affording food	Transportation	Family support	Social Engagement	Other:	
13. Hobbies/Interests						
14. Nicotine products	Never use	Type:	Amount per day or week:	History of: Age started Age ended		
15. Alcohol	Never use	Former (Quit date)	Current	How many drinks per setting:	How many days per week:	
16. Caffeine	Never use	Type:	Quantity per day:			
17. Drugs	Never use	Former (Quit date)	Current: Type: Amount/frequency:			
18. Exercise	Frequency (# days per week):	How many minutes:	Type(s):			

MARC KRESS MD & ASSOCIATES

Today's Date:

Prefix Miss Mr. Mrs. Ms. Mx. Other: Preferred Name:

Patient's Name

First Middle Last

Address

Street & Apt # City State Zip

SS# Birthdate Age: Sex assigned at birth: ☐ Female ☐Male ☐Prefer not to say

Current Gender Identity: ☐ Female ☐ Male ☐ Transgender Male ☐ Transgender Female ☐ Genderqueer ☐ Other

Relationship Status ☐ Single ☐ Married to: ☐Separated ☐ Divorced ☐ Widowed ☐ Other

Home Phone Cell Phone Other Phone

Preferred Contact: ☐Home ☐ Work ☐Cell

Any restrictions for contacting you? ☐No ☐ Yes If yes, please describe

Can we leave routine test results message for you at your preferred phone contact? ☐ Yes ☐ No

Work Phone Ext: Is it okay to call you at work? ☐ Yes ☐ No

Emergency Contact: Relationship to Patient: Phone#:

Patient's Employer Occupation

Ethnicity: ☐Hispanic ☐Non-Hispanic Language:

Race: ☐African American ☐Asian ☐American Indian/Native Alaskan ☐Native Hawaiian or Other Pacific Islander ☐White

How did you hear about us? ☐ Friend ☐ Insurance ☐ Internet ☐ Other Details:

Referring Dr.:

INSURANCE INFORMATION

Primary Ins. ID # Group #

Insured: Name DOB SS#

Relationship to the insured? ☐Self ☐Child ☐Spouse ☐Other

Secondary Ins. ID # Group #

Insured: Name DOB SS#

Relationship to the insured? ☐Self ☐Child ☐Spouse ☐Other

OTHER DOCTORS TREATING YOU

Name/Specialty Phone/Address

PRIVACY PRACTICES NOTICE & WRITTEN ACKNOWLEDGEMENT FORM

I have been offered a copy of Marc Kress MD & Assoc. Notice of Privacy Practices.

Signature of Patient/Guardian: Date:

AUTHORIZATION OF PAYMENT & RELEASE OF INFORMATION

I request payment of authorized insurance benefits be paid to Marc Kress MD & Assoc. and authorize release of medical information as needed to determine payable benefits for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature of Patient/Guardian: Date:

Would you like to share your email with us? (We don't communicate with patients that way now, but may in the future.)

Email