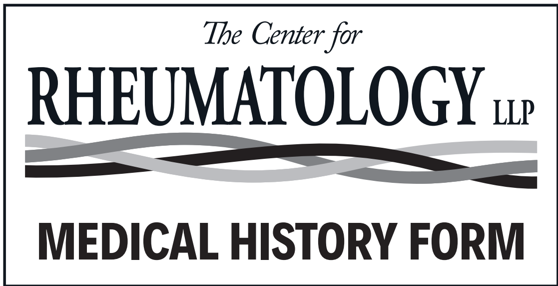

Patient Name: ______________________ DOB: ______________ Date: ______________

Chief Complaint/Reason for visit: ____

Medication List: Please list all medications, over the counter drugs and supplements you are currently taking.

Name: ex: Folic Acid	**Dosage:** ex: 1mg	**Instructions:** ex: 1 tab daily

Allergy List: Please list all things you are allergic to and how it affects you.

Name: ex: Penicillin	**Reaction:** ex: Nausea

Past Medical History: Please check if you or **your immediate family** have a history of any condition below:

	self	family member			self	family member	
Alcoholism	☐	☐	______	Kidney Disease	☐	☐	______
Anemia	☐	☐	______	Liver Disease	☐	☐	______
Autoimmuue Disorder	☐	☐	______	Lupus	☐	☐	______
Cancer	☐	☐	______	Lung Problems	☐	☐	______
Congestive Heart Failure	☐	☐	______	Osteoarthritis	☐	☐	______
Colitis	☐	☐	______	Osteoporosis	☐	☐	______
COPD	☐	☐	______	Psoriasis	☐	☐	______
Crohn's Disease	☐	☐	______	Prostate	☐	☐	______
Depression	☐	☐	______	Rheumatoid Arthritis	☐	☐	______
Diabetes	☐	☐	______	Scleroderma	☐	☐	______
GERD	☐	☐	______	Seizures	☐	☐	______
Gout	☐	☐	______	Sexually Transmitted Disease	☐	☐	______
Glaucoma	☐	☐	______	Stomach Ulcers	☐	☐	______
Heart Disease	☐	☐	______	Stroke	☐	☐	______
High Cholesterol	☐	☐	______	Thyroid Disease	☐	☐	______
High Blood Pressure	☐	☐	______	Tuberculosis	☐	☐	______
Hepatitis	☐	☐	______	Pulmonary Hypertension	☐	☐	______

Other Major Illnesses: ____

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Surgical History: Please list all past operations with dates.

____

____

____

____

Social History:

Meaningful use of electronic medical records includes the collection of the following demographic information to help identify any health disparities and improve quality of care for all patients.

Gender: (select one) ☐ Male ☐ Female

Marital Status: (select one) ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other:____________________

Race: (select one)
☐ Caucasian ☐ African American ☐ Asian ☐ Native American
☐ Native Alaskan ☐ Native Hawaiian ☐ Pacific Islander ☐ Declined

Ethnicity: (select one) ☐ Hispanic ☐ Non–Hispanic ☐ Declined

Primary Language: (select one) ☐ English ☐ French ☐ Spanish ☐ Other:____________________

Occupation:____________________ Number of Children:____________________
Number of Pregnancies:____________________ Number of Miscarriages:____________________

Tobacco Use:
☐ Never smoked
☐ Currently smoke every day: Number of packs per day: __________
☐ Currently smoke some days
☐ I have quit smoking: Age when stopped: __________

Alcohol Use:
How many days per week do you drink? __________ How drinks per day? __________
Have you ever had a problem with alcohol? ☐ Yes ☐ No

Illicit / Recreational Drug Use:
Do you use drugs? ☐ Yes ☐ No How often? __________
Have you ever had a problem with illicit drug use? ☐ Yes ☐ No

Exercise:
☐ Yes: How often? ______________ ☐ No

Contacts:

Pharmacy:
Retail:____________________ Address/Phone:____________________
Retail:____________________ Address/Phone:____________________
Mail order:____________________ Address:____________________

Names of Physicians/Other Specialists which are treating you:
Name:____________________ Phone:______________ Specialty:______________
Name:____________________ Phone:______________ Specialty:______________
Name:____________________ Phone:______________ Specialty:______________
Name:____________________ Phone:______________ Specialty:______________

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram: ____ /____ /____ Date of last eye exam: ____ /____ /____ Date of last chest x-ray: ____ /____ /____

Date of last tuberculosis test: ____ /____ /____ Date of last bone densitometry: ____ /____ /____

Constitutional:
- ☐ Recent weight gain
  amount:_______________
- ☐ Recent weight loss
  amount:_______________
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes:
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ears–Nose–Mouth–Throat:
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing

Cardiovascular:
- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory:
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting of blood or coffee–ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Increasing constipations
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary:
- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, “smoky” urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For Women Only:

Age when periods began: _________

Periods regular? ☐Yes ☐No

How many days apart? ____________

Date of last period: ____ / ____ / ____

Date of last pap: ____ / ____ / ____

Bleeding after menopause? ☐Yes ☐No

Number of pregnancies: ___________

Number of miscarriages: ___________

Musculoskeletal:
- ☐ Morning stiffness
  Lasting how long?
  ______ Minutes ______ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling
  List joints affected in the last 6 mos.
  ____
  ____
  ____
  ____
  ____

Integumentary (skin and/or breast)**:**
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands/feet in the cold

Neurological System:
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Night sweats

Psychiatric:
- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine:
- ☐ Excessive thirst

Hematologic/Lymphatic:
- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfustion / when: _________

Allergic/Immunologic:
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Patient History Form ©1998
American College of Rheumatology

Patient’s Name:____________________________ Date:____________________ Physician initials:__________

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PATIENT FINANCIAL RESPONSIBILITY FORM

I hereby authorize direct payment of medical benefits to The Center for Rheumatology, LLP for services rendered. I consent to the use or disclosure of my protected health information by The Center for Rheumatology, LLP and if needed information from other providers, for the purpose of obtaining payment for my health care bills or to conduct the healthcare operations.

I understand that I am responsible for all co–payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by my contract with my insurance plan. I understand that I am financially responsible for making payment for any balance not covered by my insurance at time of service or upon receipt of a billing statement from The Center for Rheumatology. Failure to pay for the services will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency). If your statement balance is paid by check and the check is returned unpaid by your bank for any reason, a $25.00 returned check fee will be added to your account.

All copays are due at time of visit. Any outstanding balances that haven't been collected will also be due at time of visit. In some circumstances, you may be responsible for paying your deductible or coinsurance upfront for certain treatments and procedures. For these treatments, we would contact your insurance company prior to your visit to verify your benefits and to determine what amount your insurance does not pay for, and we will attempt to collect that amount at the time of your visit or prior to your appointment. It is also the patient's responsibility to obtain the necessary referral prior to their appointments if their insurance requires it. If you do not get the proper referral you would be subject for the cost of the visit if your insurance denies your claim. If you have no insurance then you would be required to pay for the cost of the office visit before being seen.

CANCELLATION POLICY

If you are unable to make your appointment, you must notify our office one day (24 hours) prior to the appointment or you will be charged a no show fee. If you miss a follow up appointment you will be charged $50.00 dollars. If you miss a new patient appointment you will be charged a $125.00 no show fee.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form.

Printed name of patient:____

Patient Signature:____ Date:__________________

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Full Name:____ D.O.B.____________________

By signing this authorization, I authorize The Center for Rheumatology, LLP to use and/or disclose certain protected health information (PHI) about me to:

1. Please list other medical providers, family, friends, etc. who, with your permission, may receive your medical information. →

Person or Entity to Receive the Information:

____

____

____

2. Please initial:

_____________ I understand that this authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV–RELATED INFORMATION unless I exclude this information above. In the event my health information includes any of these types of information, I specifically authorize release of such information to the person(s) indicated above.

I understand that The Center for Rheumatology, LLP will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from The Center for Rheumatology, LLP. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

Printed Name of Patient or Legal Guardian:____

Signature of Patient or Legal Guardian:____

Relationship to Patient:____ Date:__________________

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