The Center for

RHEUMATOLOGY LLP

MEDICAL HISTORY FORM

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

Name:_____ DOB:_____

Reason for your visit today:

_____

In the past <u>month</u> have you experience any of the following? Check box if Yes.

- ☐ Chills
- ☐ Fatigue
- ☐ Fevers
- ☐ NIght sweats
- ☐ Unintentional weight loss
- ☐ Vision loss
- ☐ Blurred vision
- ☐ Cavities
- ☐ Dry mouth
- ☐ Dry eyes
- ☐ Trouble swallowing/dysphagia
- ☐ Nosebleed/epistaxis
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Jaw pain
- ☐ Nasal sores
- ☐ Oral ulcers
- ☐ Red eye
- ☐ Sinusitis/sinus congestion
- ☐ Tinnitus/ringing in ears
- ☐ Cough
- ☐ Hemoptysis/coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Chest pain
- ☐ Edema/leg swelling
- ☐ Palpitations
- ☐ Raynaud's/purple fingers in cold
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Blood in stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Dysuria/painful urination
- ☐ Genital lesions
- ☐ Hematuria/blood in urine
- ☐ Recurrent UTI
- ☐ Urinary frequency
- ☐ Urinaty incontinence
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Heat intolerance
- ☐ Polydipsia/increased thirst
- ☐ Extremity numbness
- ☐ Gait disturbance/diffulty walking
- ☐ Headache
- ☐ Memory loss
- ☐ Tingling
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Frequent infections
- ☐ Hives
- ☐ Itching
- ☐ Nail changes
- ☐ Photosensitivity/sun sensitive
- ☐ Psoriasis
- ☐ Rash
- ☐ Scalp tenderness
- ☐ Skin lesion
- ☐ Back pain
- ☐ Height loss
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Morning stiffness:
  How long?_____
- ☐ Muscle cramping
- ☐ Myalgia/muscle pain
- ☐ Neck pain
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Lymphadenopathy/
  swollen lymph nodes

<u>IF you have rheumatoid arthritis:</u>

From a scale of 1 (normal) to 10 (maximum), how much does the rheumatoid affect your activities of daily living? (E.g., cleaning, washing, cooking, shopping, etc.)

Your answer:_____

Have you recently experienced or developed any of the following?

Infection? If so, which type and did you receive antibiotics? _____

Allergy? To what and what was the reaction? _____

Were diagnosed with a new medical condition? _____

Did you have any surgery? Who was your surgeon? _____

Were you prescribed any new medications? _____

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The Center for
RHEUMATOLOGY LLP

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 keep 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 an appointment, you will be charged $50.00. The $50.00 fee must be paid prior to being scheduled for another appointment. If you miss a new patient appointment twice, you will not be rescheduled.

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

Printed name of patient:_____

Patient Signature:_____ Date:_____

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The Center for
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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:

_____

_____

_____

1a. Name and phone number of your emergency contact:_____

2. Do you give our office permission to leave you a detailed message? ☐ Yes ☐ No

If we must leave a detailed message, please check the preferred method(s) of contact:

☐ Home phone ☐ Cell phone ☐ Work phone

3. 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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