Arthritis Care P.C.

Patient Registration Form

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Appointment date and time will be made upon receipt of this paperwork

Date________________

Patient______________________________________ Address_________________________________

Dear____,

Welcome to Arthritis Care PC. We look forward to your upcoming appointment. Our goal is to provide high quality rheumatology specialty care- from making an accurate diagnosis to the development of effective treatment and management strategies. We strive to be responsive to your needs, to offer the latest options in treatment, and give good old fashioned compassionate care.

PLEASE COMPLETE FULLY the enclosed registration packet, leaving no unanswered questions (to the best of your ability). **Please have any and all medical records from other physicians and practices sent to us prior to your appointment. We need your doctors referral form that documents specific questions they may have.** This helps us manage and correlate your care, as well as having accurate information to assist in your diagnosis.

Please arrive **15 minutes before** your scheduled appointment time. **At this practice we confirm appointment by VOICE CONTACT with you at least 3 working days ahead of your scheduled appointment.** If you do not receive person to person confirmation, your consultation will be cancelled and given to another patient. So personally confirm if you have not heard from us.

Remember we charge for all CONFIRMED APPOINTMENTS THAT ARE MISSED or CANCELED LATE. Please plan ahead.

Fax , Mail or drop off in person this paperwork to Arthritis Care PC .

Please consult our office brochures or receptionist for insurance participation.

Thank you for your time,

Arthritis Care PC

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Patient Information

Last Name ____________________ First Name ____________________ Middle Name ______________
Date of Birth __________________________ Social Security # ________________________________
Address: Street ______________________________ City/State ________________________ ZIP ________
Home# __________________________ Cell# ______________________ Email ___________________________
Employer ____ Work# __________________________
Emergency Contact __________________________ Relation ________________ Phone# ______________

Name of Spouse _________________________ Spouses Soc.Sec. # ________________________________
Spouses Date of Birth _________________________ Spouses Employer ___________________________

Gender (Select one) Male / Female
Marital Status (Select one) Single / Married / Divorced / Widow / Significant Other
Race (Select one)
African American / Asian / Caucasian / Native American / Native Alaskan /
Native Hawaiian / Pacific Islander
Ethnicity (Select one) Hispanic / Non-Hispanic
Primary Language (Select one) English / French / Spanish / Other __________________________
Origin of Birth ____

Primary Care Physician _______________________________________ Phone# ______________________
Referring Physician ____ Phone# ______________________

Guarantor Information

Person Responsible for the bill (if other than the patient) OR Parent if the Patient is a Minor

Legal Guardian's relationship to patient Parent / Step Parent / Other ________________________
Last Name ________________________ First Name ____________________ Middle Name _____________
Address: Street __________________________________ City/State ______________________ ZIP ________
Home # _____________________________ Work# _______________________ Cell# ______________________

Insurance Information

Primary Insurance: ____
ID# ______________________________________ Group# ____
Subscriber's Name _________________________________ DOB ________________ SS# _______________

Secondary Insurance: ____
ID# ______________________________________ Group# ____
Subscriber's Name _________________________________ DOB ________________ SS# _______________

Medicare Part D Prescription plan:
Prescription Insurance: ___________________________________ ID# ___________________________
Group# __________________ Subscriber's Name __________________ DOB ____________ SS# __________

Is Insurance current and active? Yes ☐ No ☐

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Medical History Form

Patient Name:______________________________________ DOB:__________________

Chief Complaint/Reason for Visit: ____

____

Previous Evaluation/Treatment for this problem:

____

____

Medication List: Please List all Medications, over the counter drug, herbal remedies and supplements you are taking

Please Provide a printed list of your medications if you are on multiple medications

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

____

____

Father age_______ Health___________ Age of death_________Cause of death__________________

Mother age_______ Health___________Age of death_________Cause of death__________________

Number of Siblings ________________________ Number of Children_______________________________

Past Medical History: Please check if yourself or immediate family have any condition below

	Self	**Family**		**Self**	**Family**
Alcoholism	☐	☐	Kidney Disease	☐	☐
Anemia	☐	☐	Liver Disease	☐	☐
Auto Immune Disorder	☐	☐	Lupus	☐	☐
Cancer	☐	☐	Lung Problems	☐	☐
Congestive Heart Failure	☐	☐	Osteoarthritis	☐	☐
Colitis	☐	☐	Osteoporosis	☐	☐
COPD	☐	☐	Psoriasis	☐	☐
Crohn's Disease	☐	☐	Prostate problems	☐	☐
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	☐	☐			

Other Major Illnesses ____

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Surgical History: Please List all PAST operations with dates:

____
____
____
____

Vaccinations: Please write the date
Pneumococcal ____________ Influenza____________ Shingles______________ PPD______________

Social History:
Occupation: ____

Work History:
Are you currently work? Yes ☐ No ☐ Where?______________________________
How long have you worked there and what do you do? ______________________________
If you are not working, why? ______________________________
Are you Disabled? Yes ☐ No ☐ Duration of being on disability? ______________________
Do you receive Disability Benefits? Yes ☐ No ☐ Dates ______________________
Do you receive any other benefits? (i.e. no fault, Workers Comp, Unemployment etc.) please list them ______________________________

Tobacco Use

Never Smoked	☐	Currently smoke some days	☐
Currently smoke every day	☐	Packs per day: ___________________	
I have Quit	☐	Age when stopped:________________	
Caffeine Beverages	☐	How many per day_________________________	

Alcohol Use: How often do you drink (days/week)_________________ 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: Do you exercise? Yes ☐ No ☐ How Often?______________________________
What type of exercise? ______________________________

Pharmacy: Please list all the pharmacies used & check where scripts from here will go
Retail:_______________________________Address/Phone:_____________________________ ☐
Retail:_______________________________ Address/Phone:_____________________________ ☐
Mail order:___________________________ Address/Phone:_____________________________ ☐

Name of physicians / other specialists who are treating you:
Name:_______________________________Phone:____________________Specialty:________________
Name:_______________________________Phone:____________________Specialty:________________
Name:_______________________________Phone:____________________Specialty:________________
Name:_______________________________Phone:____________________Specialty:________________

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Review of Systems

Place a check mark next to any problems that have significantly affected you recently or in the past

Constitutional
- Weight Gain ☐
- Weigh Loss ☐
- Fatigue ☐
- Fever/Chills ☐
- Recent illness ☐
- Loss of appetite ☐

Skin
- Rash ☐
- Sun Sensitivity ☐
- Hair Loss ☐
- Color changes in toes or fingers from cold ☐
- Pitting of the nails ☐

Neurological
- Headaches ☐
- Numbness/tingling ☐
- Muscle Weakness ☐
- Dizziness ☐
- Seizure ☐

Ear/Nose/Throat/Mouth
- Loss of Vision ☐
- Eye Pain ☐
- Inflamed Eyes ☐
- Dry Eyes ☐
- Sores mouth or nose ☐
- Dryness of mouth ☐
- Swollen glands ☐

Gastrointestinal
- Nausea ☐
- Vomiting ☐
- Diarrhea ☐
- Constipation ☐
- Loss of Control ☐
- Bloody stools ☐
- Heartburn ☐

Genitourinary
- Blood in urine ☐
- Protein in urine ☐
- Loss of control ☐
- Urinary infections ☐
- Sexually transmitted diseases ☐
- Painful intercourse (vaginal dryness) ☐

Cardiovascular
- Pain in chest ☐
- Irregular heart beat ☐
- Murmur ☐

Endocrine
- Heat or cold intolerance ☐
- Excessive thirst ☐
- Excessive urination ☐

Hematologic
- Easy Bruising or bleeding ☐
- Enlarged lymph nodes ☐
- Night sweats ☐

Psychiatric
- Depression ☐
- Hallucinations ☐
- Sleep Trouble ☐
- Memory problems ☐
- Suicidal thoughts ☐

Musculoskeletal
- Morning stiffness ☐
- Joint Pain ☐
- Joint Swelling ☐
- Neck Pain ☐
- Back Pain ☐

Respiratory
- Shortness of Breath ☐
- Frequent Cough ☐
- Coughing Blood ☐
- Exposure to Tuberculosis ☐

For Women Only Regular Menses? Yes ☐ No ☐ Last Menstrual period ________________
Have you ever had a Bone Density Test? Yes ☐ No ☐ When?________ Where?_____________

Please Answer what you have tried

Why are you here?____

What have you taken for pain?____________________________________

What previous treatments have you tried (Physical therapy, Chiropractic, Acupuncture, injections)?

____

Tests: X-rays __________________ Stress test _______________________ Dexa________________

Lab work_______________________________ Colonoscopy__________________________________

MRI____________________________________ CT Scan______________________________________

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Payment of Medicare/Medicaid Benefits

I request that payment of authorized Medicare/Medicaid benefits be made either to me or on my behalf to Arthritis Care PC, for services rendered. I authorize Arthritis care PC to release to the Health Care Financing Administration and its agents, any medical information needed to determine benefits or benefits payable for related services.

Assignment of Insurance Benefits

I hereby authorize direct payment of medical benefits to Arthritis Care PC, for services rendered. I understand that I a financially responsible for any balance not covered by my insurance.

- Co-payments are due at time of service.
- Personal balances are due with in 30 days of billing.

★ I am responsible for knowing whether my insurance is active or not.
★I am responsible for knowing if the visit and procedures are covered by my insurance.
★I am responsible for any charges and services that are not covered by my insurance.

Authorization for Release of Information

I consent to the use or disclosure of my protected health information by Arthritis Care PC, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the healthcare operations of Arthritis Care PC. I understand that diagnosis of treatment of me by Arthritis Care PC, may be conditioned upon my consent as evidenced by my signature on this document.

Administrative Fees

- Cancelation or now show with less than 2 working days notice **$50**
- No Show or less than 3 working days notice for a new patient appointment **$100**
- Non payment of copay at time of service, surcharge added **$20**
- Returned Check fee **$25**
- Charge for copying medical records and x-rays **$.75 page**
- The office reserves the right to charge a fee for administrative forms (i.e. FMLA, Disability forms etc). **Fee to be paid in advance of service.**

✦Privacy Notice Available Upon Request

✦This office uses HIXNY and other available online systems for electronic medical record exchange with other medical practices.

✦HIPPA Policies practiced at ARTHRITIS CARE PC

By signing I acknowledge all the above information.

Patients Signature____**Date:**____________________

if minor
Guardian's Signature_______________________________________ Date:___________________