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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

Arthritis Care P.C.

Patient Registration Form

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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Patient Registration Form

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

Name	Dosage	Instructions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Auto Immune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>
GERD	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>			
Other Major Illnesses	_____				

Arthritis Care P.C.

Patient Registration Form

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: _____

Arthritis Care P.C.

Patient Registration Form

Review of Systems

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

Constitutional

- Weight Gain
- Weight 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 _____

Arthritis Care P.C.

Patient Registration Form

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 am financially responsible for any balance not covered by my insurance.

- Co-payments are due at time of service.
- Personal balances are due within 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 or treatment of me by Arthritis Care PC, may be conditioned upon my consent as evidenced by my signature on this document.

Administrative Fees

- Cancellation or no 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: _____