Arthritis Care Troy
2414 Fifteenth St.
Troy, NY 12180

Arthritis Care P. C.

Patient Registration Form

Arthritis Care Clifton Park
2 Emma Lane
Clifton Park, NY 12065

Ph: (518)271-1813 Fax: (518)271-1931 Billing: (518)348-1276

Christopher Huyck, M.D., FACR
Richard Bryan, M.D. FACR
Michael Allen, M.D.
Elizabeth Gentile, RN, BSN, FNP
Barbara Nguyen, PA-C

Date:_____

Patient _____ Address_____

Appointment Date:_____Location: _____2414 15th St, Troy, NY 12180

Time: _____AM/PM _____2 Emma Ln, Clifton Park, NY 12065

Dear_____

Welcome to Arthritis Care P.C. where our goal is to be responsive to your needs and provide high quality healthcare. Our Board-Certified Rheumatologists offer years of experience and strive to provide personalized specialty care- from making an accurate diagnosis to the development of effective treatment and management strategies. We offer state of the art diagnostic testing and the latest treatment options to optimally treat and manage all forms of rheumatic diseases.

We request that you compete this registration packet and return to our office via fax, mail, or in person. In addition, please have a referral and medical records sent to us from your other physicians prior to your appointment. Your doctor's referral will document specific questions and concerns they may have, and helps us to manage and correlate your care which can assist you with your diagnosis.

Please ensure to verbally confirm your new patient consultation with us at least 2 business days ahead of your scheduled appointment, and plan to arrive 15 minutes early. **If we are unable to verbally confirm your appointment, your consultation may be rescheduled.** If you are unable to make your appointment please notify us as soon as possible before a late cancelation fee is charged. All confirmed appointments that are missed will result in a no-show fee of $50.00, please plan ahead.

Please consult our office for insurance participation.

Thank you, Arthritis Care P.C.

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Patient Information

Last Name:_____First Name:_____ MI:____

D.O.B.___/___/____ Gender: M / F Primary Language:_____

Home Address:_____City:_____

State:_____Zip: _____ Email:_____

Race: ❑American Indian/Alaska Native ❑Asian ❑Black/ African American
❑Native Hawaiian/Pacific Islander ❑ White/Caucasian ❑Other:_____

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino

Origin of Birth: _____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widow ❑Significant Other

Emergency Contact(s):

Name:_____ Name:_____

Relation:_____ Relation:_____

Phone #:_____ Phone #:_____

Insurance Information:

Primary Insurance:_____

ID#_____Effective Date:___/___/____

Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Insurance Plan: _____

ID#_____Effective Date:___/___/____

Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Information (continued):

Guarantor Information (person responsible for bill if other than patient OR parent if patient is a minor):

Last Name:_____First Name:_____ MI:_____

Home Address:_____City:

State:_____ Zip: _____ Email:_____

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Pharmacies:

Primary:_____ Phone #:_____

Address:_____

Secondary:_____ Phone #:_____

Address:_____

Mail Order:_____ Phone #:_____

Address:_____

Medication List: Please list all medications, over the counter meds, as- needed meds, vitamins, and supplements you are currently taking. You may also provide a printed list of your medications.

Medication	Dose	Directions

*Attach separate sheet if needed

Allergy List: Please list all allergies and any side effects they cause.

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Surgical History: Please list past surgeries you have done with dates.

Family History: # of siblings_____ # of Children_____

Father age:_____ Health:_____ Age of Death: _____ Cause of death: _____

Mother age:_____ Health:_____ Age of Death: _____ Cause of death: _____

Medical History: Please mark if you or your immediate family members have any of the conditions below:

Self/ Family	Self/ Family	Self/ Family
❑ ❑Alcoholism	❑ ❑Glaucoma	❑ ❑Prostate problems
❑ ❑Anemia	❑ ❑Heart disease	❑ ❑Rheumatoid arthritis
❑ ❑Cancer	❑ ❑High blood pressure	❑ ❑Scleroderma
❑ ❑High cholesterol	❑ ❑Seizures	❑ ❑ Congestive heart failure
❑ ❑Colitis	❑ ❑Kidney disease	❑ ❑ STIs
❑ ❑COPD	❑ ❑Liver disease	❑ ❑Stomach ulcers
❑ ❑Crohn's disease	❑ ❑Lupus	❑ ❑Stroke
❑ ❑Depression	❑ ❑Lung disease	❑ ❑Thyroid disease
❑ ❑Diabetes	❑ ❑Osteoarthritis	❑ ❑Tuberculosis
❑ ❑GERD	❑ ❑Osteoporosis	

Tobacco use: ❑Never smoked ❑Smoke somedays ❑Smoke every day, Packs per day:_____
❑Former smoker, Age when stopped:_____

Illicit/ Recreational Drugs: ❑No ❑Yes If yes, what?_____

Have you ever had a problem with illicit drug use? ❑Yes ❑No

Alcohol use: ❑Never ❑Rarely ❑Occasionally/often

Have you ever had a problem with alcohol? ❑Yes ❑No

Exercise: Do you enjoy exercising? ❑Yes ❑No

Caffeine Use: How many cups of coffee per day?_____

Work History: Do you currently work? ❑Yes ❑No If yes, occupation:_____

If you are not working why?_____ Are you disabled? ❑Yes ❑No

If you are disabled, duration of disability?_____

Why are you being sent to a Rheumatologist?_____

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Review of Symptoms

Place a check mark next to any problems you currently have or have had in the past:

Constitutional
- ❑Weight gain
- ❑Weight loss
- ❑Fatigue
- ❑Fever
- ❑Chills
- ❑Loss of appetite

Respiratory
- ❑Shortness of breath
- ❑Cough
- ❑Wheezing
- ❑exposure to tuberculosis

Skin
- ❑Rashes
- ❑Sun sensitivity
- ❑Hair loss
- ❑nail changes

Eyes
- ❑Eye pain
- ❑Dryness
- ❑Blurred vision
- ❑Vision loss
- ❑Irritation

Gastrointestinal
- ❑Constipation
- ❑Diarrhea
- ❑Heartburn
- ❑Nausea
- ❑Bloody stool
- ❑Vomiting

Neurological
- ❑Dizziness
- ❑Headaches
- ❑ Numbness/Tingling
- ❑Muscle weakness
- ❑Seizure

Ear/Nose/Throat
- ❑Hearing difficulty
- ❑Constant bloody nose
- ❑Dry mouth
- ❑Difficulty swallowing
- ❑Sore Throat

Genitourinary
- ❑Frequent UTIs
- ❑Sexually transmitted disease
- ❑Sexual difficulties
- ❑Other symptoms

Psychological
- ❑Depression
- ❑Hallucinations
- ❑Memory loss
- ❑Sleep trouble

Cardiovascular
- ❑Chest pain
- ❑Irregular heart beat
- ❑Heart murmur

Musculoskeletal
- ❑Joint pain/stiffness
- ❑Muscle pain
- ❑Morning stiffness
- ❑Joint swelling

Endocrine
- ❑Excessive thirst
- ❑Excessive urination
- ❑Heat/cold intolerance

Hematological
- ❑Easy bruising
- ❑Easy bleeding
- ❑Enlarge lymph nodes

Additional Information: Have you had any of these tests performed? If so, date of last exam: X-rays:_____ Dexa:_____ MRI:_____ CT Scan:_____
Stress Test:_____ Lab work:_____ Colonoscopy:_____
What have you tried for pain?_____ Have you tried previous treatments? (physical therapy, chiropractic, acupuncture, injections)

_____

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Doctors list

Primary Care:_____ Phone:_____

Address: _____ Fax:_____

_____

Cardiology:_____ Phone:_____

Address: _____ Fax:_____

_____

Pulmonary:_____ Phone:_____

Address: _____ Fax:_____

_____

Dermatology:_____ Phone:_____

Address: _____ Fax:_____

_____

Gastrointestinal:_____ Phone:_____

Address: _____ Fax:_____

_____

Physical Therapy:_____ Phone:_____

Address: _____ Fax:_____

_____

Neurology:_____ Phone:_____

Address: _____ Fax:_____

_____

Orthopedic:_____ Phone:_____

Address: _____ Fax:_____

_____

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Payment of Medicare/Medicaid Benefits

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

Assignment of Insurance Benefits

I hereby authorize direct payment of medical benefits to Arthritis Care, P.C., for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. In addition:

- Co-payments
- Personal balances are due with in 30 days of billing
- I am responsible or 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, P.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct the healthcare operations of Arthritis Care, P.C. I understand that diagnosis of treatment of me by Arthritis Care, P.C, may be conditioned upon my consent as evidenced by my signature on this document. In addition, I give Arthritis Care, P.C. consent to import and review prescribed medications.

Administration Fees

- Cancellation or no show with less than 24 hrs notice is a $50.00 fee
- Returned check fee is $25.00
- Charge for copying of medical records is $0.75 per 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. HIPAA policies are practiced at Arthritis Care, P.C.

By signing I acknowledge the above information:

Patient Signature:_____ Date:_____ If under the age of 18: Guardians Signature:_____