Patient Registration Information

Title (Circle One) Mr. Mrs. Ms. Miss **Name:** First M. Last

Date of Birth: **Last 4 Digits SS#**

Address:

Phone Numbers: Home Cell

Work

Email Address:

Gender: M F (Circle One)

Right or **Left-Hand** (Circle One)

Marital Status

- Single ☐
- Married ☐
- Widowed ☐
- Divorced ☐
- Other ☐

Ethnicity

- African American ☐
- Asian ☐
- Caucasian ☐
- Hispanic ☐
- Native American ☐
- Native Hawaiian ☐
- Other ☐
- Decline to state ☐

Referring Physician

Primary Care Physician

Pharmacy: Name:

Address:

Primary Insurance Secondary Insurance

Insurance Name:

Member ID #

Group #

Insured Name:

Insured Date of Birth

Relationship to Insured

Permission to Bill

By my signature below, I authorize Rheumatology Associates P.C., to act as my agent in helping obtain payment from my insurance company. I authorize payment directly to my doctor and I permit this form to be used as my "Signature on file" for all my insurance submissions. I authorize release of any information that is required to obtain payment to my doctor. I understand THAT I AM RESPONSIBLE for payments to Rheumatology Associates P.C., for charges for the above patient regardless of my insurance coverage. I also understand that in the event my insurance company denies payment, I am responsible for the balance in full. I am aware that I am responsible for any copayments and/or deductibles as in specified under my insurance contract.

Signature **Date**

Patient Name: _____

(Please Print) (Date)

HIPAA- Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard to protect your health information. The purpose of the Notice of Privacy Practice is to explain how Rheumatology Associates P.C., may use or disclose your healthcare information. The notice also explains the rights that you are guaranteed under HIPPA regulations.

Though we take great care to protect the integrity and confidentiality of your healthcare information, we are required by HIPPA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have been provided access to the notice. If you would like to review the notice it is available in our waiting room.

_____

Please sign here Date

Permission to Share Medical Information

My medical information may be obtained and exchanged verbally to:

_____

Name/Relationship Phone #

_____

_____

ePrescribing

ePrescribing gives our practice information about which drugs are covered by insurance, what medications you are already taking or have tried, and allows your doctor to prescribe and renew prescriptions electronically. This will ensure your prescriptions are filled in a more timely manner, reduce errors and prevent adverse drug reactions to help your doctor treat you more efficiently.

By signing you are aware that Rheumatology Associates P.C., can request and use your prescription medication history for treatment purposes.

_____

Please sign here Date

I understand that there are insurance plans (**i.e., Husky/Medicaid**, even if it is secondary) that Rheumatology Associates P.C., does not accept, and that it is my responsibility to verify your participation with my insurance before I am seen. I also understand that it is my responsibility to obtain any referrals requires by my insurance.

I am responsible for paying my full copayment at the time of each visit. If I cannot pay at the time of service, I understand that my appointment will be rescheduled.

Notice of 24 hours or more is required for any appointment cancellation.

_____

Please sign here Date

Rheumatology Associates, P.C.

Christopher Scola, MD John Vischio, MD Ioana C Stanescu, MD

Patient History

NAME: _____ Date: _____/_____/_____

Last First M. I.

DOB: _____ AGE: _____ Sex: ❑ F ❑ M

Height: _____ Weight: _____

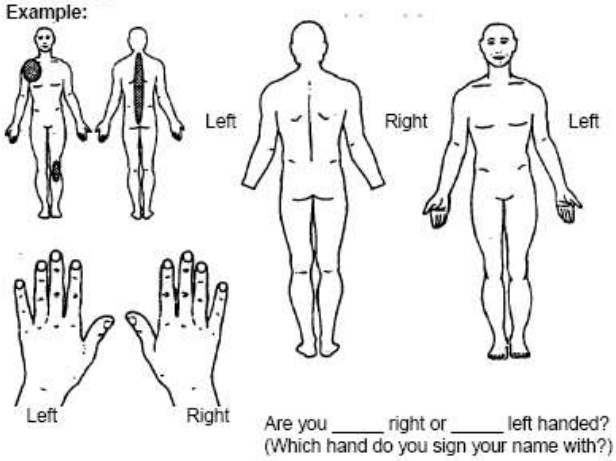
Whom do we thank for referring you here? _____

Name of your primary care physician: _____

Describe briefly your present symptoms: _____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

When did your symptoms start? _____

What diagnosis have you been given, if any?

Please list the names of other practitioners you have seen for this problem: _____

Previous treatment for this problem (include physical therapy, surgery, and injections; medications to be listed later):

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (Check if "yes")

	Yourself	Relative		Relationship
1. Arthritis (type unknown)	❑	❑	1	
2. Osteoarthritis	❑	❑	2	
3. Rheumatoid arthritis	❑	❑	3	
4. Gout	❑	❑	4	
5. Lupus or "SLE"	❑	❑	5	
6. Ankylosing spondylitis	❑	❑	6	
7. Childhood arthritis	❑	❑	7	
8. Sjogren's syndrome	❑	❑	8	
9. Osteoporosis	❑	❑	9	
10.Psoriasis/psoriatic arthritis	❑	❑	10	

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) _____
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems
❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones
❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS

Other significant illnesses (please list): _____

Previous Operations

	Type	*Year*	*Reason*
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Any previous fractures? ❑ No ❑ Yes Describe _____

Any other serious injuries? ❑ No ❑ Yes Describe _____

Do you smoke? ❑ Yes ❑ No ❑ In the past - How long ago? _____

Do you drink alcohol? ❑ No ❑ Yes: Usual drink: _____ How much: _____

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

Do you use drugs for reasons that are not medical? ❑ No ❑ Yes If yes, please list: _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	**Dose (include strength and number of pills per day)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

PERSONAL HISTORY

What is your highest educational level? ❑ High school ❑ High School Graduate
❑ Some College Courses ❑ College graduate ❑ Advanced degree

What is your current or past occupation? _____

Are you currently working? ❑ Yes ❑ No If yes, hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability? _____

What date did this disability begin? _____

With whom do you currently live? _____

How much exercise do you get each week? _____ What kind of exercise? _____

FAMILY HISTORY

	IF LIVING		**IF DECEASED**	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of siblings: _____ Number living _____
Number of children _____ Number living _____ List ages of each _____
Health of children: _____

Date of last eye exam _____ Date of last chest x-ray _____
Date of last bone density test _____
Result of last TB (PPD) test: ❑ Never done ❑ Negative ❑ Positive Date test performed: _____

GENERAL
❑ Recent weight gain; how much____
❑ Recent weight loss: how much____
❑ Fatigue
❑ Weakness
❑ Fever
❑ Night sweats

MUSCLE/JOINTS/BONES
❑ Morning stiffness
Lasting how long ____ Minutes
____ Hours
❑ Joint pain
❑ Muscle weakness
❑ Joint swelling
List joints affected in the last 6 months

_____
_____
_____
_____

EARS
❑ Ringing in ears
❑ Loss of hearing

EYES
❑ Pain
❑ Redness
❑ Loss of vision
❑ Double or blurred vision
❑ Dryness
❑ Feels like something in eye

MOUTH
❑ Sore tongue
❑ Bleeding gums
❑ Sores in mouth
❑Loss of taste
❑ Dryness
❑ Recent increase in tooth cavities

NOSE
❑ Nosebleeds
❑ Loss of smell

THROAT
❑ Frequent sore throats
❑ Hoarseness
❑ Difficulty in swallowing
❑ Pain in jaw while chewing

NECK
❑ Swollen glands
❑ Tender glands

HEART AND LUNGS
❑ Pain in chest
❑ Irregular heart beat
❑ Sudden changes in heart beat
❑ Shortness of breath
❑ Difficulty in breathing at night
❑ Swollen legs or feet
❑ Cough
❑ Coughing of blood
❑ Wheezing

STOMACH AND INTESTINES
❑ Nausea
❑ Heartburn
❑ Stomach pain relieved by food
❑ Vomiting of blood/"coffee grounds"
❑ Yellow jaundice
❑ Increasing constipation
❑ Persistent diarrhea
❑ Blood in stools
❑ Black stools

KIDNEY/URINE/BLADDER
❑ Difficult urination
❑ Pain or burning on urination
❑ Blood in urine
❑ Cloudy, "smoky" urine
❑ Pus in urine
❑ Discharge from penis/vagina
❑ Frequent urination
❑ Getting up at night to pass urine
❑ Vaginal dryness
❑ Rash/ulcers
❑ Sexual difficulties
❑ Prostate trouble

BLOOD
❑ Anemia
❑ Bleeding tendency

SKIN
❑ Easy bruising
❑ Redness
❑ Rash
❑ Hives
❑ Sun sensitive
❑ Skin tightness
❑ Nodules/bumps
❑ Hair loss
❑ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM
❑ Headaches
❑ Dizziness
❑ Fainting or loss of consciousness
❑ Numbness or tingling in hands/feet
❑ Memory loss
❑ Muscle weakness

PSYCHIATRIC
❑ Depression
❑ Excessive worries
❑ Difficulty falling asleep
❑ Difficulty staying asleep

For women only:
Age when periods began: _____
Number of pregnancies: _____
Number of miscarriages: _____
Have you reached menopause?
❑ No ❑ Yes If yes, at what age: ____
Date of last Pap smear: _____
Date of last mammogram: _____

If you are still having periods:
Are they regular? ❑ Yes ❑ No
How many days apart? _____