RHEUMATOLOGY ASSOCIATES

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Thank you for selecting our practice for your Rheumatologic care. We are so happy to have you!

Enclosed are your new patient information forms to complete prior to your visit. Please use **blue or black ink only**. Present these forms along with your insurance card and photo ID to our receptionists. We cannot accept electronic versions of insurance cards. **Please arrive 15 minutes prior to your appointment time. If you arrive without all forms completed or without your insurance card, we may have to reschedule your appointment.**

Our practice utilizes wonderful nurse practitioners. You will alternate seeing your physician and their NP as a patient here. The nurse practitioners were trained directly under their supervising physician. Your care and medical decision making is 100% in collaboration with the physician. Once you establish care with a provider in our office, you will remain with that provider and their team. It's our policy that we do not allow changing of physicians within the practice. If your physician is out for a leave of absence, one of our other physicians will care for you in their absence.

Your copay is due at the time of your visit and will be collected at check in. Please consult your insurance company regarding any questions about your specialist copay.

If you have an insurance plan which requires an insurance referral to be seen by us, that is the patient's responsibility to contact your primary care physician regarding your referral prior to your appointment. This is the policy of your insurance company. We are not allowed to obtain a referral for any of your visits here. If there is not a referral on file, any outstanding balances become patient responsibility.

Medicare deductibles are due at the beginning of January. You are responsible for this deductible unless you have a secondary insurance that will cover the expense of your deductible.

Any questions you may have concerning our fees, payments, or insurance claims should be directed to our billing staff at 205-930-3002.

If copies of records or lab reports need to be sent to another doctor, please inform your physician's nurse at the time of your visit. If you, an insurance company, or an attorney's office need your

records, we must first have a signed authorization of release to send the records. There are fees for completion of forms and copies of records released to the patient.

Our LUMA reminder system will contact you 7 days and again 48 hours before your appointment to remind you of your appointment date and time. If you have a conflict with your scheduled appointment, please notify our office as soon as possible and we will do the same. This information is also available on the patient portal. You will receive your patient portal invitation via email at your first appointment. **No patient will be seen without an appointment.**

Due to a high volume of calls, you will get an automated attendant when you call our office. This allows us to call you back with the information you need instead of making multiple calls. Please leave your name, date of birth, the physician you see in our office, and a phone number where you can be reached. Not leaving this information may make it impossible to locate you in our system and we will not be able to return your call.

To request a refill, please contact your pharmacy so they can request it electronically. This is the most efficient way to process these requests, including narcotic prescriptions. If you leave a message for the nurse, they will return your call by the end of the day. Please leave only one message; messages left after 3:30 may be returned the following business day.

We hope this letter of introduction will make you feel more comfortable when you arrive at our office. Please do not hesitate to call if you have any questions. Again, we thank you for choosing our doctors, and we welcome you to our practice.

Kindest regards,

Holleigh Seales

Holleigh Seales
Practice Administrator

RHEUMATOLOGY ASSOCIATES

Patient Information (Please Print)

Today's Date _____ Referring Doctor _____

Primary Care Doctor _____ Pharmacy _____

Patient's Name (First and Last) _____

Email Address _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Other Contact Phone (if any) _____

Date of Birth _____/_____/_____ Social Security # _____ - _____ - _____

Patient's Employer _____

Business/Work Phone _____ Marital Status S M D W

Language Preference_____Race_____Ethnic Group_____Gender M F

Spouse's Employer _____

Spouse's Business/work phone _____

Emergency Contact:

_____ Relationship: _____ Phone: _____

Insurance Information

Please tell us which insurance is primary if you have more than one

Medicare # _____ Primary Secondary

Medicaid # _____ Primary Secondary

Insurance Company: _____ Primary Secondary

Subscribers Name: _____

Policy # _____ Group # _____

Subscribers Date of Birth: _____/_____/_____ Amount of Specialist Co-pay $ _____

All co-pays and payments are due at the time of service

Patient Confidentiality Form

I understand that Rheumatology Associates has a legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality of patient information and to safeguard the privacy of patient information. I may elect to provide Rheumatology Associates three names of individuals who may obtain information concerning my treatment.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I understand that on occasion Rheumatology Associates may have the need to contact me at home or work. Employees of Rheumatology Associates may:

(please initial one)

_____ leave non detailed messages on any number provided by the patient

_____ leave detailed messages on any number provided by the patient

_____ not leave messages

I agree that my obligations under this agreement regarding patient information will continue as long as I am a patient of Rheumatology Associates, or at the time I provide written revocation of this document.

_____	_____
Patient Signature	Date

RHEUMATOLOGY ASSOCIATES

Agreement to Pay

Please read the following and sign below:

I understand and agree that I am financially responsible to pay all amounts and charges submitted by Rheumatology Associates for services rendered during the course of my treatment, including hospitalization, unless the physician or contractors are otherwise obligated to accept payment from a third-party payer.

I understand and agree that I am financially responsible to the Physician even though there may be insurance or other third-party coverage. Failure to make payments when requested is the basis for legal action and I agree to pay all costs of collection, including a reasonable attorney's fee.

I understand and acknowledge that payment is due in full upon receipt of an invoice statement.

I agree that my obligations to make payments are joint and reasonable and that the Physician may pursue either or both parties for payment, and that I, and not any insurance company, will be solely responsible for the entire bill, even though the cost of this medical care may exceed the amount reimbursed by third-party insurers.

==========

Responsibility for Non-Covered Services

The physician may determine that there are certain routine services that are necessary for the maintenance of good health and standard medical care that are not covered by your Blue Cross, PMD contract, other insurance contract, HMO, or other third-party insurance coverage. Charges not covered may include services, and/or any annual deductibles, or co-pays. The Physician will only order tests that are deemed medically necessary in the Physician's opinion and I may question whether a certain service is covered by my insurance carrier.

I acknowledge and understand this non-covered service policy of the Physician. I agree to be fully responsible for all charges by the Physician for such non-covered charges in amounts set forth on a fee schedule which will be available at my request.

_____ _____

Date Patient

_____ _____

Date Responsible Party

AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

Patient History Form

Date of first appointment: ____/____/____ (MONTH / DAY / YEAR) Time of appointment: _____ Birthplace: _____

Name: _____ (LAST / FIRST / MIDDLE INITIAL / MAIDEN) Birthdate: ____/____/____ (MONTH / DAY / YEAR)

Address: _____ (STREET / APT#) Age _____ Sex: ❑ F ❑ M

_____ (CITY / STATE / ZIP) Telephone: Home: (____) _____ Work: (____) _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses: _____

EDUCATION *(circle highest level attended):*

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/Average per work: _____

Referred here by: *(check one)* ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Describe briefly your present symptoms: _____

_____

_____

_____

_____

Date symptoms began *(approximate)*: _____

Diagnosis: _____

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

_____

_____

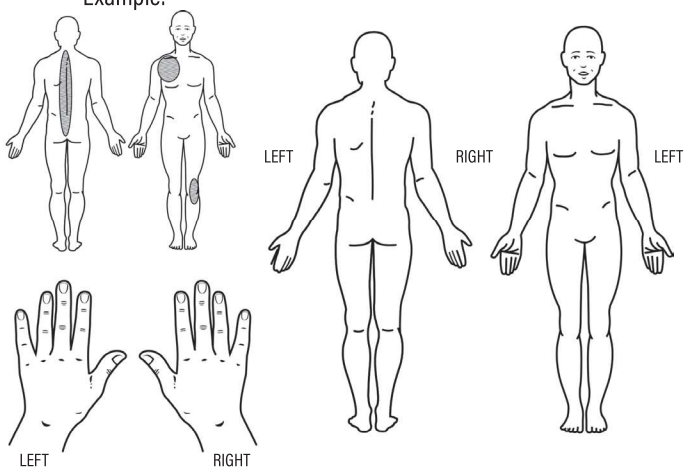
_____

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

_____

_____

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



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Other arthritis conditions: _____

Patient's Name: _____ Date: _____ Physician Initials: _____

SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last mammogram: ____/____/____ Date of last eye exam: ____/____/____ Date of last chest x-ray: ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- ☐ Recent weight gain amount _____
- ☐ Recent weight loss amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ears-Nose-Mouth-Throat

- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty swallowing

Cardiovascular

- ☐ Chest Pain
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory

- ☐ Shortness of breath
- ☐ Difficulty breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary

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

For Women Only:

Age when periods began: _____

Periods regular? ☐ Yes ☐ No

How many days apart? _____

Date of last period?____/____/____

Date of last pap?____/____/____

Bleeding after menopause? ☐ Yes ☐ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ☐ Morning stiffness

  Lasting how long?

  _____Minutes _____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling

  List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold

Neurological System

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Night sweats

Psychiatric

- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine

- ☐ Excessive thirst

Hematologic/Lymphatic

- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when_____

Allergic/Immunologic

- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Patient's Name: _____ Date: _____ Physician Initials: _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ☐ Yes ☐ No ☐ Past – How long ago? _____

Do you drink alcohol? ☐ Yes ☐ No Number per week _____

Has anyone ever told you to cut down on your drinking?

☐ Yes ☐ No

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No

If yes, please list: _____

_____

Do you exercise regularly? ☐ Yes ☐ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

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

Do you wake up feeling rested? ☐ Yes ☐ No

PAST MEDICAL HISTORY

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

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High Blood Pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness *(please list)* _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

PREVIOUS SURGERIES

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

Any previous fractures? ☐ No ☐ Yes *Describe:* _____

Any other serious injuries? ☐ No ☐ Yes *Describe:* _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children _____

_____

Do you know any blood relative who has or had: (check and give relationship)

☐ Cancer _____	☐ Heart disease _____	☐ Rheumatic fever _____	☐ Tuberculosis _____
☐ Leukemia _____	☐ High blood pressure _____	☐ Epilepsy _____	☐ Diabetes _____
☐ Stroke _____	☐ Bleeding tendency _____	☐ Asthma _____	☐ Goiter _____
☐ Colitis _____	☐ Alcoholism _____	☐ Psoriasis _____	

Patient's Name: _____ Date: _____ Physician Initials: _____

MEDICATIONS

Drug allergies: ☐ No ☐ Yes If yes, please list: _____

_____

Type of reaction: _____

PRESENT MEDICATIONS *(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)*

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

Drug names/Dose	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		☐	☐	☐	
Circle any you have taken in the past Flurbiprofen Diclofenac + misoprostil Aspirin (including coated aspirin) Celecoxib Sulindac Oxaprozin Salsalate Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Choline magnesium trisalcylate Diclofenac					
Pain Relievers					
Acetaminophen		☐	☐	☐	
Codeine		☐	☐	☐	
Propoxyphene		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab		☐	☐	☐	
Golimumab		☐	☐	☐	
Hydroxychloroquine		☐	☐	☐	
Penicillamine		☐	☐	☐	
Methotrexate		☐	☐	☐	
Azathioprine		☐	☐	☐	
Sulfasalazine		☐	☐	☐	
Quinacrine		☐	☐	☐	
Cyclophosphamide		☐	☐	☐	
Cyclosporine A		☐	☐	☐	
Etanercept		☐	☐	☐	
Infliximab		☐	☐	☐	
Tocilizumab		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	

RHEUMATOLOGY ASSOCIATES, P.C.

For Office Use Only

GL ☐

PN ☐

FN ☐

Considering all the ways in which illness and health conditions may affect you at this time, please make a mark below to show how you are doing.

Very Well 0 1 2 3 4 5 6 7 8 9 10 Very Poor

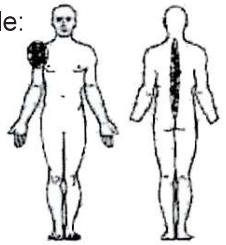
How much pain have you had because of your condition over the past week?
Place a mark on the line below to indicate how severe your pain has been:

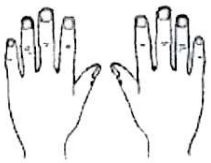
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

MILD PAIN (2) MODERATE PAIN (5) SEVERE PAIN (8)

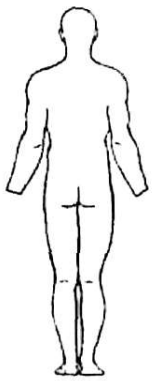
Please shade all the locations of your pain over the past week on the body figures and hands.

Example:

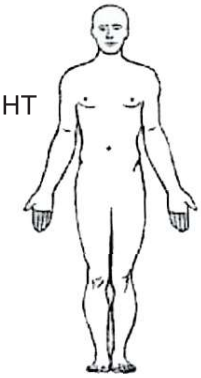




LEFT RIGHT



LEFT



RIGHT LEFT

Activity Level-Right now, are you able to:	Without any Difficulty	With some Difficulty	With much Difficulty	Unable
1. Dress yourself including buttons and laces?	0	1	2	3
2. Get in and out of bed?	0	1	2	3
3. Lift a full cup or glass to your mouth?	0	1	2	3
4. Walk outdoors on flat ground?	0	1	2	3
5. Wash and dry your entire body?	0	1	2	3
6. Bend down to pick up something off the floor?	0	1	2	3
7. Turn regular faucets on and off?	0	1	2	3
8. Get in and out of a car, bus, train, or airplane?	0	1	2	3
9. Walk 2 miles?	0	1	2	3
10. Participate in a sports game as you would like?	0	1	2	3

List any doctors you would like your records sent to:

1. _____
2. _____

Since your last visit, please list any of the following:

Hospitalizations: _____

_____

Surgeries: _____

_____

NEW drug allergies: _____

_____

NEW medical problems: _____

_____

NEW symptoms/infections: _____

_____

Do you have a living will? YES NO

Do you have a Durable Power of Attorney?

YES NO

Do you have a healthcare Proxy? YES NO

If yes, please list: _____

IF OVER THE AGE OF 65:

Have you had any falls in the last year?

If yes, how many? _____

Did the fall(s) result in injury? _____

1= 0.33
2= .67
3= 1.0
4= 1.33
5= 1.67
6= 2.0
7= 2.33
8= 2.67
9= 3.0
10= 3.33
11= 3.67
12= 4.0
13= 4.33
14= 4.67
15= 5.0
16= 5.33
17= 5.67
18= 6.0
19= 6.33
20= 6.67
21= 7
22= 7.33
23= 7.67
24= 8.0
25= 8.33
26= 8.67
27= 9.0
28= 9.33
29= 9.67
30= 10.0