IMS Rheumatology

New Patient Registration Sheet

Personal Information

Patient's first name: _____ Initial: ____ Last name: _____

DOB: ___/___/____ Age: ____ Birth place: _____ Social security #: ____-____-____
Gender: □ M □ F

Address: _____ City: _____ State: _____ Zip: _____

Home phone: ____-____-_____ Cell: ____-____-_____ Email: _____@_____.com

Occupation: _____ Work: ____-____-_____

Marital Status: □ Single □ Married □ Widowed □ Divorced

Significant other: □ Alive/ Age: ___ □ Deceased/ Age: ___

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Race: □ American Indian □ Black or African American □Hispanic □ White □Other_____

(Circle) Grade School: 7 8 9 10 11 12 College: 1 2 3 4 Graduate School: _____

Emergency Contact Information

Name: _____ DOB: _____

Relation to patient: _____ Phone: ____-____-_____

Financial Responsible Party Information

Name: _____ DOB: ___/___/_____ Phone: ____/____/_____

Health Insurance Information

Insurance Company Name: _____ Address: _____

Subscriber/Policy #: _____ Group #: _____

Subscriber Name: (Last) _____ (First) _____ DOB: ___/___/____

Relation to Patient (if not self): □ Spouse□ Parent □Other _____

Secondary:

Insurance Company Name: _____ Address: _____

Subscriber/Policy #: _____ Group #: _____

Subscriber Name: (Last) _____ (First) _____ DOB: ___/___/____

IMS Rheumatology
New Patient Registration Sheet

Relation to Patient (if not self): □Spouse □ Parent □Other _____

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:_____

Do you have an orthopedic surgeon? □Yes □No If Yes, Name: _____

Describe briefly your present symptoms: _____

_____

_____

_____

Date symptoms began (approximate):_____Example_____

Diagnosis: _____

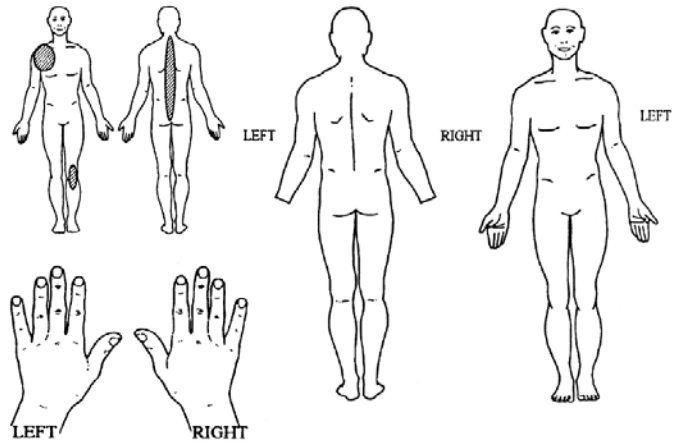
Previous treatment for this problem, including physical therapy, surgery and injections: (Medications to be listed later)

_____

_____

_____

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.

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

_____

_____ _____

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: _____

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: ____/____/____

Date: _____Patient Name: _____ DOB: _____

IMS Rheumatology
New Patient Registration Sheet

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

Constitutional	Gastrointestinal	Integumentary (Skin and/or Breast)
□ Recent weight gain/Amount ___lbs.	□ Nausea	□ Easy bruising
□ Recent weight loss/Amount ___lbs.	□ Vomiting of blood or coffee ground material	□ Redness
□ Fatigue	□ Stomach pain relieved by food or milk	□ Rash
□ Weakness	□ Jaundice	□ Hives
□ Fever	□ Increasing constipation	□ Sun sensitive or Sun allergy
Eyes	□ Persistent diarrhea	□ Tightness
□ Pain	□ Constitutional	□ Nodules/ bumps
□ Redness	□ Black stools	□ Hair loss
□ Loss of vision	□ Heartburn	□ Color changes of hands or feet in the cold
□ Double or blurred vision	**Genitourinary**	**Neurological System**
□ Dryness	□ Difficult urination	□ Headaches
□ Feels like something In eye	□ Pain or burning on urination	□ Dizziness
□ Itching eyes	□ Blood in urine	□ Fainting
Ears-Nose-Mouth-Throat	□ Cloudy, "smoky" urine	□ Muscle spasm
□ Ringing in ears	□ Pus in urine	□ Loss of consciousness
□ Loss of hearing	□ Discharge from penis/ vagina	□ Sensitivity or pain of hands and / or feet
□ Nosebleeds	□ Getting up at night to pass urine	□ Memory loss
□ Loss of smell	□ Vaginal dryness	□ Night sweats
□ Dryness in nose	□ Rash/ ulcers	**Psychiatric**
□ Runny nose	□ Sexual difficulties	□ Excessive worries
□ Sore tongue	□ Prostate trouble	□ Anxiety
□ Bleeding gums	**For Women Only**	□ Easily losing temper
□ Sore in mouth	□ Age when periods began? ____	□ Depression
□ Loss of taste	□ Periods Regular? □ Yes □ No	□ Agitation
□ Dryness of mouth	□ How many days apart? ____	□ Difficulty falling asleep
□ Frequent sore throats	□ Date of last period? ___/___/___	□ Difficulty staying asleep
□ Hoarseness	□ Date of last pap? ___/___/___	**Endocrine**
□ Difficulty in swallowing	□ Bleeding after menopause? □ Yes □ No	□ Excessive thirst
Cardiovascular	□ Number of pregnancies? ____	**Hematologic/Lymphatic**
□ Pain in chest	□ Number of miscarriages? ____	□ Swollen glands
□ Irregular heart beat	**Musculoskeletal**	□ Tender glands
□ Sudden changes in heart beat	□ Morning Stiffness/ Lasting how long? __Hours __Minutes	□ Anemia
□ High blood pressure	□ Joint pain	Bleeding tendency
□ Heart murmurs	□ Muscle weakness	□ Transfusion/ When? ___/ ___/___
Respiratory	□ Muscle tenderness	**Allergic /Immunologic**
□ Shortness of breath	□ Joint swelling	□ Frequent sneezing
□ Difficulty in breathing at night	□ List joints affected in the last 6 months	□ Increased susceptibility to infection
□ Swollen legs or feet	_____	
□ Cough	_____	
□ Coughing of blood	_____	
□ Wheezing (asthma)	_____	

Date: _____Patient Name: _____ DOB: _____

IMS Rheumatology
New Patient Registration Sheet

Social History		Past Medical History		
Do you drink caffeniated beverages?		Do you now or have you ever had:		
Cup/ Glasses per day __		□ Heart problems	□ Goiter	□ Epilepsy
Do you smoke? □ Yes □ No □ Past		□ Cancer	□ Cataracts	□ Rheumatic fever
How long ago?		□ Leukemia	□ Nervous breakdown	□ Colltis
Do you drink alcohol? □ Yes □ No		□ Diabetes	□ Headaches	□ Psoriasis
Cup/ Glasses per week __		□ Stomach ulcers	□ Kidney disease	□ High blood pressure
Has anyone ever told you to cut down on your drinking?		□ Jaundice	□ Anemia	□ Tuberculosis
□ Yes □ No		□ Pneumonia	□ Emphsema	□ Glaucoma
Do you use drugs for reasons that not medical?		□ HIV/ AIDS	□ Asthma	□ Stroke
□ Yes □ No				
Do you exercise regulary? □ Yes □ No		Other significant illness (please list)_____		
Type _____		_____		
Amount per week? _____				
How many hours of sleep do you get a night? ____		Natural or Altnerative Therapies (chiropractic, magnets, massage, over		
Do you get enough sleep at night? □ Yes □ No		the counter preparations, etc.) _____		
Do you wake up feeling rested? □ Yes □ No		_____		

Previous Operations				
Type	Year	Reason		
1				
2				
3				
4				
5				
6				
7				
Any previous fractures? □ Yes □ No				
Describe: _____				
Any serious injuries? □ Yes □ No				
Describe: _____				

Family History				
<u>If Living:</u>			<u>If Deceased:</u>	
	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 of any blood relative who has or had: (check and give relationship)				
□ Heart problems	□ Goiter	□ Epilepsy	□ HIV/ AIDS	
□ Cancer	□ Cataracts	□ Rheumatic fever	□ Asthma	
□ Leukemia	□ Nervous breakdown	□ Colltis	□ Stroke	
□ Diabetes	□ Headaches	□ Psoriasis	□ Pneumonia	
□ Stomach ulcers	□ Kidney disease	□ High blood pressure	□ Emphsema	
□ Jaundice	□ Anemia	□ Tuberculosis	□ Glaucoma	

Date: _____Patient Name: _____ DOB: _____

IMS Rheumatology
New Patient Registration Sheet

Drug allergies: □ Yes □ No To what? _____

_____

Type of reaction: _____

_____

Present Medications: List any medications you are taking, including such items as aspirin, vitamins, laxatives, calcium and other supplements etc.

Name of drug	Dose (Include strength & # 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			□	□	□

PAST MEDICATIONS: Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. Record your comments in the spaces provided.

Drug names & Dosage	Length of time	Please check: Helped? A lot	Some	Not at all	Reactions
		□	□	□	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)					
Circle any you have taken in the past:					

Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin)

Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin (ibuprofen)

Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)

Pain Relievers					
Acetaminophen (Tylenol)		□	□	□	
Codeine (Vicodin, Tylenol 3)		□	□	□	
Propoxyphene (Darvon/Darvocet)		□	□	□	
Other:		□	□	□	
Other:		□	□	□	
Disease Modifying Antirheumatic Drugs (DMARDS)		□	□	□	
Auranofin, Gold pills (Ridaura)		□	□	□	
Gold shots (Myochrysine or Solganol)		□	□	□	
Hydroxychloroquine (Plaquenil)		□	□	□	
Penicillamine (Cuprimine or Depen)		□	□	□	
Methotrexate (Rheumatrex)		□	□	□	
Azathioprine (Imuran)		□	□	□	
Sulfasalazine (Azulfidine)		□	□	□	
Quinacrine (Atabrine)		□	□	□	
Cyclophosphamide (Cytoxan)		□	□	□	
Cyclosporine A (Sandimmune or Neoral)		□	□	□	
Etanercept (Enbrel)		□	□	□	
Infliximab (Remicade)		□	□	□	
Prosorba Column		□	□	□	
Other:		□	□	□	
Other:					

Date: _____Patient Name: _____ DOB: _____

IMS Rheumatology
New Patient Registration Sheet

PAST MEDICATIONS Continued					
Osteoporosis Medications		□	□	□	
Estrogen (Premarin, etc.)		□	□	□	
Alendronate (Fosamax)		□	□	□	
Etidronate (Didronel)		□	□	□	
Raloxifene (Evista)		□	□	□	
Fluoride		□	□	□	
Calcitonin injection or nasal (Miacalcin, Calcimar)		□	□	□	
Risedronate (Actonel)		□	□	□	
Other:		□	□	□	
Other:		□	□	□	
Gout Medications		□	□	□	
Probenecid (Benemid)		□	□	□	
Colchicine		□	□	□	
Allopurinol (Zyloprim/Lopurin)		□	□	□	
Other:		□	□	□	
Other:		□	□	□	
Others		□	□	□	
Tamoxifen (Nolvadex)		□	□	□	
Tiludronate (Skelid)		□	□	□	
Cortisone/Prednisone		□	□	□	
Hyalgan/Synvisc injections					
Herbal or Nutritional Supplements					
Please list supplements: _____					
Have you participated in any clinical trials for new medications? □ Yes □ No					
If yes, list: _____					
_____					
_____					

Preferred Pharmacy Information

Local Pharmacy: _____Cross Streets: _____

Address: _____City: _____ State: _____ Zip: _____

Telephone number: _____ Fax number: _____

All Co-payments and account balances are due at the time services are rendered, unless other arrangements have been made. We accept cash, check, Visa and MasterCard. Inform the front office receptionist of any changes in demographics or insurance. Failure to do so may lead to an account balance. If you have an insurance plan that requires a paper referral or authorization number, it is your responsibility to make sure the referral has been completed by your primary care physician and is in our office for your scheduled appointment time. If we do not have a referral or authorization your appointment can be rescheduled. **Give at least 48 hour notice when canceling or rescheduling an appointment, so we may use that appointment for another patient. If you are late for your appointment the doctor will be unable to see you. There is a $50 fee for No Show appointments and same day cancellations. There is a $25 fee for All NSF Returned Checks.** Please allow 48-72 hours for your prescription to be refilled. PRESCRIPTIONS WILL NOT BE REFILLED OVER THE WEEKEND.

_____ _____

Patient/Guardian Signature Date

Self-Pay

I do not have health insurance and will be responsible for services rendered here at IMS AIS. I agree to pay IMS AIS, a division of IMS, the full and entire amount of treatment given to me or to the above named patient at each visit.

_____ _____

Patient/Guardian Signature Date

Date: _____Patient Name: _____ DOB: _____

IMS Rheumatology
New Patient Registration Sheet

Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

IMS AIS, A Division of IMS, appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance denies any part of your claim, or if you or your physician elect to continue past your approved period, you will be responsible for your balance in full. Finance charges will begin to accrue on any unpaid patient responsibility balance after 90 days old.

If you fail to make any payments for which you are deemed responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by IMS, you will responsible for all cost of collecting moneys owed, including but not limited to court costs, collection agency and/or attorney fees.

I have read the above policy regarding my financial responsibility to IMS AIS, for providing rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to, IMS AIS, a division of IMS, the full and entire amount of my bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

_____ _____
Patient/Guardian Signature Date

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

_____ _____
Patient/Guardian Signature Date

Consent for Treatment and Authorization to Release Information

I hereby authorize IMS AIS, a division of IMS, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize IMS AIS, and its affiliates, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

_____ _____
Patient/Guardian Signature Date

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 48 hours prior to your appointment to cancel.
I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged for care.
Our offices will notify you in writing, via mail, if you are discharged from care.
I have read and understand the above information, and I agree to the terms described:

_____ _____
Patient/Guardian Signature Date

IMS Rheumatology
New Patient Registration Sheet

QUESTIONS, CONCERNS OR COMPLAINTS

If you have any questions or want more information about this Notice or how to exercise your privacy rights, please contact our Privacy Officer at 1-888-787-9845 or by mail at 9250 N 3rd Street, Suite 4010, Phoenix, Arizona 85020.

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with us, you may contact our Privacy Officer. To file a complaint with HHS, you may contact the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F HHH Bldg., Washington DC 20201 (OCRComplaint@hhs.gov). **We will not retaliate against you for filing a complaint.**

Signature below is acknowledgement that you have read and understand this Notice.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

RELEASE OF INFORMATION

I _____ hereby authorize IMS to release or discuss any and all information pertaining to myself or my medical records with the following people.

Name: _____ Relationship_____ Phone #:_____

Name: _____ Relationship_____ Phone #:_____

Name: _____ Relationship_____ Phone #:_____

I authorize IMS to contact me at:

Home Phone_____ Work Phone_____

May we leave a message on machine? YES_____ NO_____

Cell Phone_____ Alternate Phone_____

Patient/Guardian Signature_____ **Date_____**

Witness: _____ Date_____