# ARNOLD ARTHRITIS & RHEUMATOLOGY

## Dr. Erin Arnold

### PATIENT INFORMATION

| Patient's last name: | First name: | Today's Date: | |
|---|---|---|---|
| Mailing address: | City: | State: | ZIP code: |
| Cell phone: ( ) - | Home phone : ( ) - | Work phone no.: ( ) - | |
| Patient Date of Birth: / / | Patient Age: | Patient Sex: ☐ M ☐ F | Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ other |
| Race/Ethnicity / | Email | | |
| Primary Care Physician: | Primary Care Physician Address and Phone | | |
| If patient is a minor, please give parent/guardian names and specify relation to patient: | | | |

### IN CASE OF EMERGENCY

| Name of emergency contact person: | Relationship to patient: | Cell/Home phone no.: ( ) - | Work phone no.: ( ) - |
|---|---|---|---|

### RESPONSIBLE PARTY (GUARANTOR)

The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip the next section. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

| Guarantor's last name: | Guarantor's first name: | | |
|---|---|---|---|
| Guarantor's mailing address, if different from patient: | City: | State: | ZIP code: |
| Guarantor's phone number: ( ) - | Relationship to patient: | Guarantor's date of birth: / / | |

### OTHER INFORMATION

| Pharmacy name: | Pharmacy location: | Pharmacy phone no: ( ) - |
|---|---|---|
| How did you hear about this clinic, or who referred you here? | | |

### WORK COMP INFORMATION

| Claim Number: | Insurance Name: | Date of Injury: |
|---|---|---|
| Work Comp Insurance Address and Phone Number: | | |
| Adjuster Name: | Adjuster Phone: | Attorney Name if you have one: |

# ARNOLD ARTHRITIS & RHEUMATOLOGY

## Financial Policy, Assignment Information, and Release of Information

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor, and request medical services to be provided by AAR. I authorize (assign) any insurance or Medicare benefits to be paid directly to AAR or its assignees.

As a participant in an HMO/PPO/EPO network, I understand it is my responsibility to confirm my physician is a participating physician in my network. I am responsible for any non-covered services, supplies, co-payments or deductibles, and understand these balances owed by me will be charged to my credit card on file. Full payment is due by self-pay patients at the time of service.

I acknowledge that AAR will download benefits and prescription history prior to my visits. I understand that AAR requires a 24-hour notice of appointment cancellation, if that does not occur there is a cancellation fee of $250.00 for New Patients and $150.00 for existing patients.

This acceptance and assignment will be in force for all future services by practitioners from this office.

_____ _____

Signature of Patient or Patient's guardian/representative Date

_____

Printed name of person signing above

## Acknowledgement of Notice of Privacy Practices

I understand that as part of my health care, AAR originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality.

I understand that AAR maintains a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. The most recent version of this Notice is displayed in the waiting room area. I understand that AAR reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional written copy of this Notice at any time. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed.

I have had an opportunity to receive and review the *Notice of Privacy Practices* of AAR.

_____ _____

Signature of Patient or Patient's guardian/representative Date

_____

Printed name of person signing above

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The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was developed to protect patients' rights and confidentiality in a healthcare environment that is becoming increasingly more technologically advanced. It serves to protect patient privacy, secure health information and enhance standards to improve privacy protections and security safeguards for consumer health data.

Patient Name: _____ DOB: _____

I acknowledge that I have received notice of HIPAA privacy practices for AAR, and I would like the below listed individuals to be allowed as approved contacts for my account. I acknowledge that you may speak with them in regards to my patient information, treatment/care, appointments, and billing. I understand that I may revoke this authorization and update these approved contacts at any time.

1. _____ _____
   (Name / Relationship) Phone

2. _____ _____
   (Name / Relationship) Phone

3. _____ _____
   (Name / Relationship) Phone

At times, we will contact patients in regards to appointments, treatment, questions and care. If we are able to leave a voicemail for you if you do not answer at the time, please indicate to which phone numbers this would be allowed.

( ) Cell Phone

( ) Home Phone

( ) Work Phone

( ) Other _____

Patient signature _____ Date_____

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## RHEUMATOLOGY MEDICAL HISTORY

Name:_____

DOB : ____ /____ / ___ Date : ____ /____ / ____

Referring Doctor : _____ Local pharmacy : _____
Address : _____ Address : _____
Phone : _____ Phone : _____

## PERSONAL HEALTH HISTORY

*Briefly state your reason for seeing the doctor today. Please describe your current symptoms, when it started, and what you have done for it:*

## REVIEW OF SYSTEMS

*Please use a check mark (√) to indicate whether you have had any of the conditions listed below over the LAST MONTH :*

| **Constitutional** | **Respiratory** | **Musculoskeletal** |
|---|---|---|
| ☐ Fever | ☐ Shortness of breath | ☐ Numbness or tingling of arms/legs |
| ☐ Fatigue | ☐ Cough | ☐ Muscle Weakness |
| **Head / Eye / Ear / Nose / Throat** | **Gastrointestinal** | ☐ Swelling in joints |
| ☐ Headaches | ☐ Stomach pain or cramps | **Skin** |
| ☐ Dry eyes | ☐ Constipation | ☐ Skin rash |
| ☐ Sores in the mouth | ☐ Diarrhea | ☐ Loss of hair |
| ☐ Dry mouth | ☐ Dark or bloody stools | **Psychiatric** |
| ☐ Problems with smell or taste | **Genitourinary** | ☐ Depression – feeling blue |
| ☐ Trouble swallowing | ☐ Problems with urination | ☐ Anxiety – feeling nervous |
| **Cardiovascular** | **Hematologic** | ☐ Problems with sleeping |
| ☐ Pain in chest | ☐ Unusual bruising or bleeding | ☐ Problems with memory |
| **Social History** | | |
| ☐ Smoking cigarettes | | |
| ☐ More than 2 alcoholic drinks/day | | |
| | | |
| | | |

**Name: _____**

| *Please list all operations that you have ever had :* | | |
|---|---|---|
| **Year** | **Reason** | **Hospital** |
| | | |
| | | |
| | | |
| | | |

*Please use a check mark (V) to indicate whether you have had any of the conditions listed below :*

| **Head / Eye / Ear / Nose / Throat** | **Gastrointestinal** | **Musculoskeletal** |
|---|---|---|
| ☐ Dry eyes | ☐ Stomach ulcer | ☐ Back or spine problems |
| ☐ Cataracts | ☐ Colitis/Crohn's/Ulcerative Colitis | ☐ Osteoarthritis |
| ☐ Dry Mouth | **Genitourinary** | ☐ Rheumatoid arthritis |
| **Cardiovascular** | ☐ Kidney problem | ☐ Lupus |
| ☐ High blood pressure | **Endocrine** | ☐ Ankylosing Spondylitis |
| ☐ Heart attack | ☐ Diabetes | ☐ Gout |
| ☐ Palpitations | ☐ Thyroid disorder | ☐ Osteoporosis |
| ☐ Hyper-cholesterol | **Hematologic** | **Skin** |
| **Respiratory** | ☐ Problems with blood clotting | ☐ Psoriasis |
| ☐ Asthma | ☐ Cancer | ☐ Other skin disease |
| ☐ Severe allergies | **Neurologic** | **Psychiatric** |
| ☐ History of tuberculosis | ☐ Stroke | ☐ Depression |
| ☐ Other respiratory disease | ☐ Parkinson's disease | ☐ Alcoholism |
| | | ☐ Mental illness |
| | | ☐ Other: |

## MEDICATION HISTORY

*LIST YOUR PRESCRIBED DRUGS*

| **Name of drug** | **Strength** | **Frequency Taken** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

*OVER THE COUNTER MEDICATIONS*

| **Name of drug** | **Strength** | **Frequency Taken** |
|---|---|---|
| | | |
| | | |
| | | |

*ALLERGIES TO MEDICATIONS*

| **Name the drug** | **Reaction you had** |
|---|---|
| | |
| | |
| | |

**Name: _____**

| FAMILY HEALTH HISTORY | | | | | |
|---|---|---|---|---|---|
| | **AGE** | **SIGNIFICANT HEALTH PROBLEMS** | | **AGE** | **SIGNIFICANT HEALTH PROBLEMS** |
| **Father** | | | **Children** | □ **M**<br>□ **F** | |
| **Mother** | | | | □ **M**<br>□ **F** | |
| **Sibling** | □ **M**<br>□ **F** | | | □ **M**<br>□ **F** | |
| | □ **M**<br>□ **F** | | | □ **M**<br>□ **F** | |
| | □ **M**<br>□ **F** | | **Grandmother**<br>***Maternal*** | | |
| | □ **M**<br>□ **F** | | **Grandfather**<br>***Maternal*** | | |
| | □ **M**<br>□ **F** | | **Grandmother**<br>***Paternal*** | | |
| | □ **M**<br>□ **F** | | **Grandfather**<br>***Paternal*** | | |

| SOCIAL HISTORY | | | | | |
|---|---|---|---|---|---|
| **HABITS** | | | | | |
| **Tobacco** | Do you use tobacco? | | | ☐ Yes | ☐ No |
| | ☐ Cigarettes – pks/day | ☐ Chew - #/day | ☐ Pipe - #/day | ☐ Cigars - #/day | |
| | ☐ # of years | | ☐ Or years quit | | |
| **Alcohol** | Do you drink alcohol? | | | ☐ Yes | ☐ No |
| **Drugs** | Do you currently use recreational or street drugs? | | | ☐ Yes | ☐ No |
| **Occupation** | What is your current occupation? | | | | |
| | If retired, what was your past occupation? | | | | |
| **Caffeine** | ☐ None | ☐ Coffee | ☐ Tea | ☐ Cola | |
| | # of cups/cans per day | | | | |

*Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. <u>There are no right or wrong answers</u>. Please answer exactly as you think or feel.*

**Name: _____**

**1.) Please place a check mark (√) in the appropriate spot for the <u>ONE best answer</u> for your abilities at this time:**

| | **OVER THE LAST WEEK,** were you able to: | Without **ANY** Difficulty (0) | With **SOME** Difficulty (1) | With **MUCH** Difficulty (2) | **UNABLE** To Do (3) |
|---|---|---|---|---|---|
| a. | Dress yourself, including tying shoelaces and doing buttons? | | | | |
| b. | Get in and out of bed? | | | | |
| c. | Lift a full cup or glass to your mouth? | | | | |
| d. | Walk outdoors on flat ground? | | | | |
| e. | Wash and dry your entire body? | | | | |
| f. | Bend down to pick up clothing from the floor? | | | | |
| g. | Turn regular faucets on and off? | | | | |
| h. | Get in and out of a car, bus, train or airplane? | | | | |
| i. | Walk two miles or three kilometers, if you wish? | | | | |
| j. | Participate in recreational activities and sports as you would like? | | | | |

**2.) Please indicate how severe your pain has been because of your condition OVER THE PAST WEEK?**

| NO PAIN | O 0 | O 0.5 | O 1.0 | O 1.5 | O 2.0 | O 2.5 | O 3.0 | O 3.5 | O 4.0 | O 4.5 | O 5.0 | O 5.5 | O 6.0 | O 6.5 | O 7.0 | O 7.5 | O 8.0 | O 8.5 | O 9.0 | O 9.5 | O 10 | SEVERE PAIN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| | | | |
|---|---|---|---|
| When did the pain begin? | | | |
| What makes you feel better? | | | |
| Worse? | | | |
| Do you have pain at rest? ☐ Yes ☐ No | | Do you have pain with activity? ☐ Yes ☐ No | |

**3.) Please place a check mark (√) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:**

| | | None (0) | Mild (1) | Moderate (2) | Severe (3) | | | None (0) | Mild (1) | Moderate (2) | Severe (3) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Left Fingers | | | | | i. | Right Fingers | | | | |
| b. | Left Wrist | | | | | j. | Right Wrist | | | | |
| c. | Left Elbow | | | | | k. | Right Elbow | | | | |
| d. | Left Shoulder | | | | | l. | Right Shoulder | | | | |
| e. | Left Hip | | | | | m. | Right Hip | | | | |
| f. | Left Knee | | | | | n. | Right Knee | | | | |
| g. | Left Ankle | | | | | o. | Right Ankle | | | | |
| h. | Left Toes | | | | | p. | Right Toes | | | | |
| q. | Neck | | | | | r. | Back | | | | |

**4.) Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:**

| VERY WELL | O 0 | O 0.5 | O 1.0 | O 1.5 | O 2.0 | O 2.5 | O 3.0 | O 3.5 | O 4.0 | O 4.5 | O 5.0 | O 5.5 | O 6.0 | O 6.5 | O 7.0 | O 7.5 | O 8.0 | O 8.5 | O 9.0 | O 9.5 | O 10 | VERY POORLY |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| |
|---|
| When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? ☐Yes ☐No<br>If "Yes", please indicate the number of minutes _____ or hours _____ until you are as limber as you will be for the day |
| How you feel TODAY compared to ONE WEEK AGO? Please check only one.<br>☐ Much better ☐ Better ☐ The Same ☐ Worse ☐ Much Worse |
| How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK? |
| NO PROBLEM ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 MAJOR PROBLEM |