Rheumatology Associates, PLLC

Patient Information

Referring Provider: _____ Phone: _____

Address: _____

Patient's Name: _____

Sex: M F Date of birth: _____ Age: _____ S.S. #: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____

Place of Employment: _____ Work #: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Are you on Disability? Y / N Do you have a Medicare card? Y / N

INSURED PARTY INFORMATION

What is the name of your insurance company? Primary: _____ Secondary: _____

Insured's name (First, MI, Last): _____

Employer: _____

Date of Birth: _____ Age: _____ S.S. #: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Rheumatology Associates PLLC.

Any account that isn't paid in a timely manner may be sent to a third party collection agency. An additional collection fee of 35% will be the responsibility of the patient.

By signing below, I certify that I have read, understand and comply with the policies stated herein.

X _____ _____

Signature of patient or parent if minor Date

Rheumatology Associates, PLLC

Patient Name: _____ Acct. #: _____

EDUCATION (Please circle highest level attended)

Grade School _____ Junior High School 7 8 9 College 1 2 3 4

High School 10 11 12 Graduate School _____

Occupation: _____ Number of hours worked / average per week: _____

HOME CONDITIONS

Check one: ☐ House ☐ Apartment

Do you have stairs to climb? ☐ Yes ☐ No If yes, how many? _____

Number of people in household? _____ Relationship and age of each: _____

_____

Who does most of the housework? _____ Who does most of the shopping? _____

On the scale below, circle a number which best describes your situation:

Most of the time, I function . . . 1 (Very Poorly) 2 (Poorly) 3 (OK) 4 (Well) 5 (Very Well)

Because of health problems, do you have difficulty: (Please check the appropriate response for each question)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, pens, etc.)	☐	☐	☐
Walking?	☐	☐	☐
Climbing stairs?	☐	☐	☐
Descending stairs?	☐	☐	☐
Sitting down?	☐	☐	☐
Getting up from a chair?	☐	☐	☐
Touching your feet while seated?	☐	☐	☐
Reaching behind your back?	☐	☐	☐
Reaching behind your head?	☐	☐	☐
Dressing yourself?	☐	☐	☐
Going to sleep?	☐	☐	☐
Staying asleep due to pain?	☐	☐	☐
Obtaining restful sleep?	☐	☐	☐
Bathing?	☐	☐	☐
Eating?	☐	☐	☐
Working?	☐	☐	☐
Getting along with other family members?	☐	☐	☐
In your sexual relationship?	☐	☐	☐
Engaging in leisure time activities?	☐	☐	☐
With morning stiffness?	☐	☐	☐
Do you use a cane, crutches, walker or wheelchair?	☐	☐	☐

What is the hardest thing for you to do? _____

Are you receiving disability? ☐ Yes ☐ No

Are you applying for disability? ☐ Yes ☐ No

Do you have a medically related lawsuit pending? ☐ Yes ☐ No

SYSTEMS REVIEW

As you review the following, please check any of those problems which apply to you.

GENERAL

- ☐ Recent weight gain / amount _____ lbs.
- ☐ Recent weight loss / amount _____ lbs.
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Chills
- ☐ Sweats

NERVOUS SYSTEM

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle Spasm
- ☐ Loss of Consciousness
- ☐ Sensitivity, pain, numbness or tingling of hands and/or feet
- ☐ Stroke
- ☐ Seizures / Epilepsy

EARS

- ☐ Ringing in ears
- ☐ Loss of hearing

EYES

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

NOSE

- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness
- ☐ Sinus trouble

MOUTH

- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness

THROAT

- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing

BLOOD

- ☐ Anemia
- ☐ Bleeding tendency

MENSTRUAL

- ☐ Age when periods began _____
- ☐ Periods regular? ☐ Yes ☐ No
- ☐ How many days apart? _____
- ☐ Date of last period? _____
- ☐ Date of last pap smear? _____
- ☐ Bleeding after menopause? ☐ Yes ☐ No

NECK

- ☐ Swollen glands
- ☐ Tender glands

HEART AND LUNGS

- ☐ Pain in chest
- ☐ Irregular heart beat / palpitations
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing / Asthma
- ☐ Sputum production

STOMACH AND INTESTINES

- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or drink
- ☐ Yellow jaundice
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn
- ☐ Diverticulitis
- ☐ Ulcers
- ☐ Gall stones
- ☐ Colitis
- ☐ Irritable bowel symptoms
- ☐ Hiatus hernia

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 troubles

SKIN

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

MUSCLES / JOINTS / BONES

- ☐ Morning stiffness
- ☐ Lasting how long?
  _____ hours _____ minutes
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling

List joint affected in the last 6 months:

_____

_____

_____

_____

_____

_____

HABITS

Do you drink coffee? ☐ Yes ☐ No

Cups per day? _____

Do you smoke? ☐ Yes ☐ No

Cigarettes per day? _____

Do you drink alcohol? ☐ Yes ☐ No

How much per week? _____

Has anyone ever told you to cut down on drinking? ☐ Yes ☐ No

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

Please list: _____

_____

How many pillows do you use to sleep on each night? _____

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

Do you wake up feeling rested? ☐ Yes ☐ No

Date of last eye examination _____

Date of last chest x-ray _____

Date of last tuberculosis test _____

Rheumatology Associates, PLLC

Patient Name: _____ Acct. #: _____

PAST PERSONAL HISTORY

Are you allergic to any medications? ☐ Yes ☐ No

If yes, list medication: _____

Describe reaction: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, where? _____

Reason? _____

CHILDHOOD DISEASES (CIRCLE)

Measles	Chickenpox	Scarlet Fever	Mononucleosis
Mumps	Tuberculosis	Hepatitis	Rheumatic Fever

Previous operations / Hospitalizations:

Reason / Diagnosis	Year	Operation	Hospital / City
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Any previous broken bones? ☐ Yes ☐ No If yes, describe? _____

Any other serious injuries? ☐ Yes ☐ No If yes, describe? _____

FAMILY HISTORY

	If Living		If Deceased	
	Age	Health	Age at death	Cause of death
Father				
Mother				

Number of brothers _____ Number living _____ Number deceased _____

Number of sisters _____ Number living _____ Number deceased _____

Number of your children _____ Ages of each _____ Number living _____ Number deceased _____

Serious illnesses of children: _____

_____

Do you know of any blood relatives who have had: (check and give relationship)

☐ Cancer _____ ☐ Heart disease _____ ☐ Asthma _____ ☐ High blood pressure _____

☐ Leukemia _____ ☐ Stroke _____ ☐ Diabetes _____ ☐ Bleeding disorder _____

☐ Epilepsy _____ ☐ Alcoholism _____ ☐ Gout _____ ☐ Ankylosing Spondylitis _____

☐ Colitis _____ ☐ Tuberculosis _____ ☐ Rheumatoid Arthritis _____

F=Father M=Mother S=Sister B=Brother A=Aunt U=Uncle GF=Grandfather GM=Grandmother

RHEUMATOID ARTHRITIS HISTORY FORM

Name: _____ **Date:** _____

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

Have you seen any of our physicians before? ☐ Yes ☐ No If yes, name of physician and approximate date. _____ If your name was different, please specify _____

Do you have an orthopedic surgeon? ☐ Yes ☐ No If yes, name: _____

Describe briefly your present symptoms: _____

Date symptoms began (approximate) _____

Diagnosis given? (Please list) _____

Previous treatment for this problem (include physical therapy, surgery, injections and medication): _____

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)
☐ Arthritis	☐ _____
☐ Osteoarthritis	☐ _____
☐ Rheumatoid Arthritis	☐ _____
☐ Gout	☐ _____
☐ Lupus or SLE	☐ _____
☐ Ankylosing Spondylitis	☐ _____
☐ Childhood Arthritis	☐ _____
☐ Osteoporosis	☐ _____

Other arthritis conditions: _____

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List any medications you are taking at this time, include such items as aspirin, vitamins, laxatives, calcium supplements, etc.

Patient Name: _____ Acct. #: _____

Name of Drug	Dose (include strength and number of pills per day)	How long have you taken this medication?	Results		
			A lot	Some	Not at all
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					
26.					
27.					
28.					
29.					
30.					

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	Length of time	Dosage	Results			Comments
			A lot	Some	Not at all	
1. Tylenol with codeine						
2. Clinoril						
3. Feldene						
4. Indocin						
5. Meclomen						
6. Motrin / Rufen						
7. Nalfon						
8. Naprosyn / Naproxen						
9. Tolectin						
10. Cortisone / Prednisone						
11. Benemid/Probenecid						
12. Colchicine						
13. Zyloprim / Allopurinol						
14. Plaquenil						
15. Methotrexate						
16. Imuran						
17. Cytoxan						
18. Voltaren						
19. Lodine						
20. Relafen						
21. Daypro						
22. Xeljanz						
23. Humira						
24. Enbrel						
25. Remicade						
26. Simponi						
27. Cimzia						
28. Orencia						
29. Actemra						
30. Rituxan						

POS Reorder # 1305730

Rheumatology Associates PLLC
3430 Newburg Rd Ste 250
Louisville, KY 40218

Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information.
Please review it carefully.

Protected health information (PHI) about you is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.
Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.
You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its web site.
You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.
You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.
You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.
You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.
You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.
You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.
You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.
Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.
Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.
Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.
Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Rheumatology Associates PLLC
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Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at (502)893-3963. We will not retaliate against you for filing a complaint.

By signing this contract, I am agreeing that I have read the Privacy Act given to me by Rheumatology Associates PLLC and agree with its terms.

Print Name: _____ Date Signed: _____

Signature: _____

I authorize the staff to leave detailed medical information on my voicemail on the following:

☐ Home ☐ Work ☐ Cell ☐ NONE

I authorize the staff to give information to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____