Rheumatology Care Specialists
30 LaCrue Ave, Suite 101
Tel: 610-558-4800 * Fax: 610-558-4844

Patient Registration Form:

Name:_____ **DOB:**_____ **SS#:**_____
First (Initial) Last

Address: _____ City: _____ State:_____ ZipCode:_____

Home#:_____ Cell#:_____ Work#:_____ Email:_____

Pharmacy: _____ Pharm. #: _____ **Sex:** Male_____ Female_____

Circle One: **Race:** _Asian _Black _Hispanic _White _Other **Marital Status:** _Single _Married _Divorced _Widowed

May we contact you at: **Home**? Yes__ No__ **Work**? Yes__ No__ **Cell**? Yes__ No__

I authorize **Brief** messages with medical information to be left on voicemail (check that apply) Home ___ Cell___

I authorize **Extended** messages with medical information to be left on voicemail (check that apply) Home___ Cell___

I authorize the following individual(s) to receive information pertaining to any **medical history and treatment**:

Name:_____ Relationship:_____ Phone#:_____

Name:_____ Relationship:_____ Phone#:_____

Release of Billing Information: Check here if the same as above _____

Name:_____ Relationship:_____ Phone#:_____

Name:_____ Relationship:_____ Phone#:_____

Emergency Contact: Check here if the same as above _____

Name: _____ Relationship: _____ Tel: _____

Billing and Insurance Information

Primary of Insurance Company:_____

Member ID #:_____ Group #:_____ Group Name: _____

Secondary Insurance: _____

Member ID#:_____ Group #:_____ Group Name: _____

RHEUMATOLOGY CARE SPECIALISTS
STATEMENT OF FINANCIAL RESPONSIBILITY

- I (or patient's guardian) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, or most major credit cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but not limited to):
    - Charge for returned checks
    - Charge for copying of patient medical records
    - Charge for forms completion
    - Charge for missed/rescheduled appointments

I understand that if I do not pay the "patient due" balance in a timely manner it could be sent to a collection agency and may be asked to leave the practice. I also understand that an additional 35% of my outstanding balance will be added to the amount due to cover cost of collections. I agree to pay this cost in addition to the outstanding balance for services rendered.

I understand that Rheumatology Care Specialists (RCS) uses an outsourced billing company and give RCS permission to share pertinent medical information for the sole purposes of billing my insurance company.

I understand that a $25 fee may be charged for missed/rescheduled appointments changed less than 2 business days in advance. I also understand that a reminder call is a courtesy and that it is my responsibility to know when my appointment is scheduled. I understand that if I miss 3 appointments or reschedule 3 appointments without appropriate notice I may be asked to leave the practice. I understand that a $25 fee will be charged for any returned check fees.

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to *Rheumatology Care Specialists* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Assignment of Insurance Benefits

_____

Signature of Patient, Guardian or Authorized Representative

Assignment of Medicare Benefits

I request that payment of Medicare benefits for services rendered to me by Rheumatology Care Specialists be made directly to Rheumatology Care Specialists.

_____

Signature of Patient, Guardian or Authorized Representative

RHEUMATOLOGY CARE SPECIALISTS

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPPA Compliance Officer in person or by phone at our main office number.

Signature below is only acknowledgement that I have been given the option of receiving a copy or been afforded an opportunity to review Notice of Privacy Practices for Rheumatology Care Specialists:

With my consent, Rheumatology Care Specialists may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations.

With my consent, Rheumatology Care Specialists may call my home or any other designated location and leave a message or voicemail in reference to any items that assist the practice in carrying out patient care and other activities linked to TPO. These activites may include appointment reminders, insurance items, and any call pertaining to my clinical care: including laboratory results, among others.

Rheumatology Care Specialists reserves the right to revise the Notice of Privacy Practices at any time. A revised copy may be obtained by making a request to a team member at Rheumatology Care Specialists at 30 LaCrue Ave, Ste 101, Glen Mills, PA 19342.

Though, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting Rheumatology Care Specialists use and disclose of my Protected Health Information to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign consent, Rheumatology Care Specialists may decline to provide treatment to me.

Signature:_____ Date:_____

RHEUMATOLOGY CARE SPECIALISTS
PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: __/__/__
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

Name of your primary care physician: _____

PAST MEDICAL HISTORY

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

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

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 _____

SOCIAL HISTORY

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

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

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

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

Education Level: _____

Occupation:_____

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.	

FAMILY HISTORY

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

SYSTEMS REVIEW

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
- ❑ 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
  - o Frequent urination
  - o Vaginal dryness

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

Multi-Dimensional Health Assessment Questionnaire (R808-NP2)

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. 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. There are no right or wrong answers. Please answer exactly as you think or feel. Thank you.

1. Please check (√) the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without **ANY** Difficulty	With **SOME** Difficulty	With **MUCH** Difficulty	**UNABLE** To Do
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of a car, bus, train, or airplane?	0	1	2	3
i. Walk two miles or three kilometers, if you wish?	0	1	2	3
j. Participate in recreational activities and sports as you would like, if you wish?	0	1	2	3
k. Get a good night's sleep?	0	1.1	2.2	3.3
l. Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
m. Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

FOR OFFICE USE ONLY

1.a. FN (0-10): ☐

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

2.PN (0-10): ☐

Name_____ Date of Birth _____ Today's Date_____

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

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
a. LEFT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3	i. RIGHT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3
b. LEFT WRIST	☐ 0	☐ 1	☐ 2	☐ 3	j. RIGHT WRIST	☐ 0	☐ 1	☐ 2	☐ 3
c. LEFT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3	k. RIGHT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3
d. LEFT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3	l. RIGHT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3
e. LEFT HIP	☐ 0	☐ 1	☐ 2	☐ 3	m. RIGHT HIP	☐ 0	☐ 1	☐ 2	☐ 3
f. LEFT KNEE	☐ 0	☐ 1	☐ 2	☐ 3	n. RIGHT KNEE	☐ 0	☐ 1	☐ 2	☐ 3
g. LEFT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3	o. RIGHT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3
h. LEFT TOES	☐ 0	☐ 1	☐ 2	☐ 3	p. RIGHT TOES	☐ 0	☐ 1	☐ 2	☐ 3
q. NECK	☐ 0	☐ 1	☐ 2	☐ 3	r. BACK	☐ 0	☐ 1	☐ 2	☐ 3

☐

Cat:
HS = >12
MS = 6.1-12
LS = 3.1-6
R = ≤3

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