Denton Rheumatology
Jonathan D. Reyes, M.D., P.A.
2445 West Oak Street, Suite 100 Denton, Texas 76201 Phone: (940)565-0600 Fax:(940)565-1538

Dear Patient,

We are pleased that you have chosen Denton Rheumatology for your evaluation. Dr. Reyes will conduct a complete evaluation on your first visit including a physical examination and lab work which will take one hour. Our office will schedule an appointment for you in 2 weeks after your first visit to discuss the findings of your evaluation.

Based on the insurance information provided to our office, we will verify coverage and benefits before your first visit. Verification is done as a courtesy to you, but it is *not a guarantee of coverage.* **We will require you to pay whatever amount your insurance does not cover at the time of your appointment. We accept cash and credit/debit cards only. We do not accept CHECKS OR American Express.**

- **Please be advised that Dr. Reyes DOES NOT accept new patients with illnesses or injuries related to: Disability, Auto Accidents, FMLA or Worker's Compensation. Under no circumstances will paperwork be completed related to any of the above.**

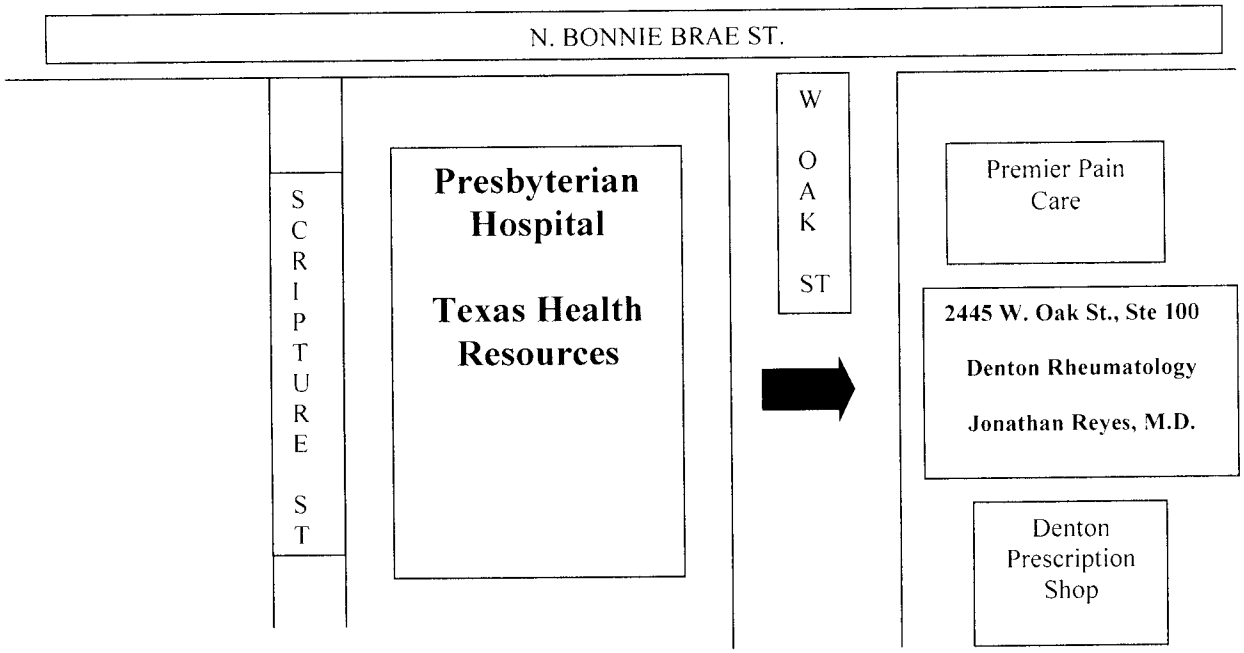
Please call us if you have any questions. We look forward to seeing you.

Sincerely,
The Staff of Denton Rheumatology

A Few Reminders About Your Appointment:

- **Morning appointments:** Please fast 10 hours prior to your appointment. You may have water, plain coffee or plain tea. You may also bring a snack to have after your blood is drawn.
- **Afternoon appointments:** No fasting is required. The office is closed for lunch between 12:00-1:00 p.m.
- Weather permitting: please wear loose, comfortable clothing such as a t-shirt and shorts. If you have concerns about facial skin rashes or fingernail changes/abnormalities, please do not wear any makeup or nail polish to your appointment
- Bring any lab and/or x-ray reports done within the past 3 months. Your physician can fax these to our office if you request them to do so **at least 3 days prior to your appointment**. It is not necessary to bring CT or MRI images, but narrative reports are helpful.
- **Failure to notify our office within 48 hours of your appointment for a cancellation will result in a missed appointment fee of $100.00. We will call you to confirm your appointment 1 week in advance. If we are unable to speak with you, we will leave a message requesting that you call the office to confirm. In the event that we do not hear from you, we will automatically cancel your appointment.** Unfortunately, we have to implement this policy due to the length of our waiting list.

Your appointment is: Day: Date: Time:



Important Information for Prospective New Patients:

1) Jonathan D Reyes MD PA / Denton Rheumatology does not participate in the evaluation, validation, verification, or certification of Long Term Disability claims. Denton Rheumatology will, upon request and in accordance with standard HIPPA guidelines make available any and all medical records within 30 days of request.

2) Forms requiring completion by Jonathan D Reyes MD PA / Denton Rheumatology including but not limited to: FMLA, Short Term Disability, Recurrent or Extended work releases will be accepted and considered on an individual basis. A Fee for Form / Document Completion (amount to be determined by acuity of forms /document) will be assessed. Payment in full will be required prior to completion of Forms /Documents.

3) Jonathan D Reyes MD PA / Denton Rheumatology does not provide nor participate in treatment plans consisting of ongoing opiate analgesics for long term or chronic pain management. Individuals requiring ongoing or recurrent opiate analgesic prescriptions will be referred to appropriate alternative Pain Management Specialty Physicians.

Patient Information

Last Name: First Name: Middle Initial:

Street Address: City: State: Zip:

Home Phone: ( ) Cell Phone: ( ) Work Phone: ( )

Email Address:

Date of Birth: / /

Gender: □ Female □ Male

Marital Status: □ Single □ Married □ Divorced □ Widowed

Race: □ Caucasian □ Black □ Hispanic □ Asian □ American Indian

Emergency Contact Person's Name:

Emergency Contact Person's Phone Number:

Emergency Contact Person's Relationship to Patient:

Name of Employer:_____

Employer Address:_____

Employer Phone:_____

Referring Physician Information

Name of Referring Physician: □ MD □ DO □ PA □ Nurse Practitioner

Street Address: City: State: Zip:

Phone: ( ) Fax: ( )

Primary Insurance Information

Name of Insurance Company:

Insurance Company Phone Number (for Providers): ( )

Insured's Name:

Insured's Date of Birth:

Insured's Relationship to Patient:

Insurance ID #:

Insurance Group #:

Secondary Insurance Information

Name of Insurance Company:

Insurance Company Phone Number (for Providers): ( )

Insured's Name:

Insured's Date of Birth:

Insured's Relationship to Patient:

Insurance ID #:

Insurance Group #:

Pharmacy Information

Pharmacy Name:

Pharmacy Address:

Pharmacy Phone: ( )

Pharmacy Fax: ( )

Name of Mail Order Pharmacy if applicable:

Denton Rheumatology

YOUR HEALTH HISTORY. In order to provide you with more effective medical care, your doctor needs certain basic information about your medical history. **PRINT** firmly using a ballpoint pen. **Please complete both sides of this form.**

Name _____ Date of Birth _____ Sex _____ Marital Status _____

Street _____ City _____ State _____ Zip Code _____

Daytime Telephone _____ Evening Telephone _____

REVIEW OF SYSTEMS: Do you have, or have you ever had, any of the following conditions? **PLEASE CHECK.**

Difficulty sleeping	_____	Kidney stones	_____
EXTREME tiredness, weakness or fatigue	_____	Palpitations or fluttering heart	_____
Frequent or severe headaches	_____	Shortness of breath	_____
Heart attack or angina	_____		

PAST MEDICAL HISTORY: Have you ever had the following conditions? **PLEASE CIRCLE** the appropriate ones and write the year you were diagnosed in the blank provided.

Anemia	_____	Diabetes	_____	Jaundice/Hepatitis	_____	Rheumatic Fever	_____
Asthma	_____	Gonorrhea	_____	Kidney Disease	_____	Stomach Ulcer	_____
Cancer	_____	High Blood Pressure	_____	Nervous Breakdown	_____	Stroke	_____
						Tuberculosis	_____

SURGERY or OPERATIONS: Please list your operations and the approximate year of occurance.

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

MEDICATIONS

Current Medications	Dosage Strength	How Often Taken

ALLERGIES: Please list **ALL** medicines you are allergic to.

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

SOCIAL HISTORY: How much do you smoke per day? _____ Do you drink two or more alcoholic beverages per day? _____

FAMILY HISTORY:

What is the health status of your mother? _____ Deceased _____ Year _____

What is the health status of your father? _____ Deceased _____ Year _____

How many brothers and sisters do you have? _____ What is the health status of your siblings? Good _____ Fair _____ Poor _____

How many children do you have? _____ What are their ages? _____

What is the health status of your children? Good _____ Fair _____ Poor _____

Has anyone in your family been diagnosed with an arthritis disease? If so, whom and what is their diagnosis? _____

Name and Telephone Number of Primary Care Physician

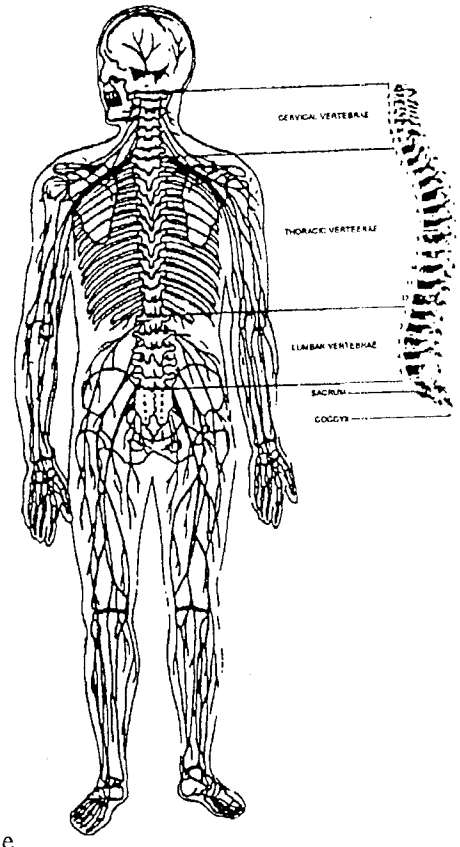
_____

Names and Telephone Numbers of All Other Physicians Currently Seen:

_____

_____

_____



Reason for Visit (Which joints/muscles hurt most):

1. _____

2. _____

3. _____

ACTIVITIES OF DAILY LIVING. In order to provide you with more effective medical care, you doctor needs certain basic information about your Activities of Daily Living.

Which of the following best describes you TODAY? Please "X" only one.

_____ I can do everything I want to do. _____ I can do most of the things I want to do, but have some limitations.
_____ I can hardly do any of the things I want to do.

How do you feel TODAY compared to ONE MONTH AGO? Please "X" only one.

_____ Better today than one month ago. _____ The same today as one month ago. _____ Worse today than one month ago.

Please indicate the **degree of difficulty** you have performing the following activities. Mark an "X" in all that apply. **Are You Able To:**

		Some Difficulty	*Great Difficulty*	*Unable to Do*
1.	Dress yourself, including tying shoelaces, and fastening buttons?	_____	_____	_____
2.	Turn regular faucets on and off?	_____	_____	_____
3.	Open cans or jars?	_____	_____	_____
4.	Walk?	_____	_____	_____
5.	Get in and out of bed?	_____	_____	_____
6.	Get up from a chair?	_____	_____	_____
7.	Get in and out of a car?	_____	_____	_____
8.	Go up or down stairs?	_____	_____	_____

Patient Financial Policy

Jonathan Reyes, M.D.

In order to reduce confusion and misunderstanding between our patients and our practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with the office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Unless either your or your health insurance carrier has made other arrangements in advance, ***full payment is due at the time of service.*** For your convenience, we accept cash, checks, Visa, MasterCard and Discover.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay authorized co-payment and/or co-insurance at the time of service. It is the policy of our office to collect this co-payment when you ***arrive*** for your appointment.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.

- In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge.

- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____

Printed Patient Name

_____

Signature of Patient or Responsible Party

_____

Date