Family Arthritis Center/AARA Patient Registration

Name: _____ Date: ___/___/___

Referring Doctor:_____ Primary Care Doctor: _____

Social Security #_____ Sex: Male/Female Age: ____ DOB:____/____/____

Marital Status: M S W D Race:_____ Ethnicity:_____ Language: English_____Other_____

Address:_____

Number and Street Unit# City State Zip

Home Phone: _____ Work Phone: _____Cell Phone: _____

Ok To Leave Message on_____Home_____Cell_____Text, Detailed- or- Brief?

Email Address: _____

Employment Status: PT FT Not Employed Student Retired Disable

Occupation: _____Employer: _____

Insurance company:_____ Policy Holder:_____

Policy Holder's SS#_____ DOS:_____ Relation to Patient:_____

Name of Spouse: _____ Cell phone: _____

Emergency Contact: _____ Phone Number:_____Relation:_____

Local Pharmacy Name:_____Phone:_____ Location:_____

Mail Order Pharmacy: _____ Phone number: _____

******** OFFICE POLICY AND GUIDELINES********

All questions concerning fees should be asked prior to service. I authorize my insurance company to make payment for all medical services directly to Family Arthritis Center/AARA. I agree that any balances will be paid by me. I also agree that if I do not pay my balance and my account goes to a Collection

Agency that I will be responsible for all collection fees and will be charged an additional 1.5% interest per month on my collection balance until the balance is paid in full.

Transfer of medical information: I authorize Family Arthritis Center/AARA to release any information necessary to secure payment for all services provided, or to further my medical care. I authorize Family Arthritis Center/AARA to view/receive patient's medical records, including but not limited to any medical history.

It is your responsibility to have your referral with you at the time of your visit. Reminders to bring your referral are a **COURTESY**: Therefore, you must know if a referral is required. If you are unsure you need to check with our office **PRIOR** to your appointment.

Please notify the office of any changes to your address and phone number. If your insurance has changed, you need to notify the office prior to your appointment otherwise you will be responsible for the full payment of the visit. Just as a friendly reminder, we bill your insurance company as a courtesy.

The office reserves your appointment time especially for you. 24-hour notice of rescheduling or cancellation is REQUIRED. We reserve the right to charge you for a **NO SHOW** or **CANCELLED** appointment the same day of the visit. This charge will be $50 for a follow-up appointment, DEXA, Injection, or Infusion; and $100 for a New Patient appointment. We are aware that emergencies can arise, but repeated cancellations and no shows will result in **DISMISSAL** from the practice. Confirmations are a **COURTESY**; therefore, you are expected to remember your appointments.

Reciept of Office Policy/Guidelines and Privacy Practices

I _____, have received a copy of Family Arthritis Center AARA's notice of privacy practices.

Thank You,

Family Arthritis Center/AARA

_____ _____

Patient's Signature Date

PATIENT HISTORY FORM Name: _____ Date: ____/____/____

PLEASE STATE THE MAIN REASON FOR YOUR VISIT: _____

_____

_____

MEDICAL HISTORY: Please check all the conditions that YOU have had

__ hypertension	__ diabetes	__ osteoarthritis
__ osteoporosis	__ rheumatoid arthritis	__ lupus
__ scleroderma	__ gout	__ fibromyalgia
__ heart attack	__ heart failure	__ rheumatic fever
__ mitral valve prolapse	__ high cholesterol	__ asthma
__ pneumonia	__ bronchitis	__ emphysema
__ tuberculosis	__ peptic ulcer	__ esophageal reflux
__ Chron's disease	__ ulcerative colitis	__ irritable bowel
__ hepatitis	__ anemia	__ blood transfusion
__ thyroid disease	__ kidney failure	__ kidney stones
__ psoriasis	__ epileptic seizures	__ stroke
__ depression	__ syphilis	__ gonorrhea

__ cancer (please specify): _____

__ fractures and other accidents (please specify): _____

__ other (please specify): _____

ORTHOPEDIC SURGERY HISTORY: please list the procedures and your age at the time of surgery:

1._____ 2. _____ 3. _____ 4. _____

5._____ 6. _____ 7. _____ 8. _____

GENERAL SURGERY HISTORY: Please list the procedures and your age at the time of surgery:

1._____ 2. _____ 3. _____ 4. _____

5._____ 6. _____ 7. _____ 8. _____

MEDICATIONS: List the medications, vitamins, minerals and calcium supplements you are taking and dosage

1._____ 2. _____ 3. _____ 4. _____

5._____ 6. _____ 7. _____ 8. _____

MEDICATION ALLERGIES: List any medications you are allergic to and the symptoms you had.

1._____ 2. _____ 3. _____ 4. _____

5._____ 6. _____ 7. _____ 8. _____

PERSONAL/SOCIAL HISTORY: Marital status: _____ Children: _____ Work: _____

Tobacco use: _____ None _____ Smoke ___ packs per day for ___ years. ____ Quit _____ When _____

Alcohol use: ____ None ____ Socially ____1-2 drinks daily ____ 3 or more drinks daily

Recreational drugs: ____ None ____ Marijuana ____ Other

Exercise: ___ Do not exercise ____ Exercise ___ times per week, specify type: _____

FAMILY HISTORY: List any family history that you are aware of in the spaces below:

Mother: Living age ___ Problems: _____ Deceased age: ____ Cause: _____

Father: Living age ___ Problems: _____ Deceased age: ____ Cause: _____

Sisters and Brothers: Number: ____ Serious illness or cause of death _____

Children: Number: ____ Serious illness or cause of death _____

PATIENT HISTORY page 2 NAME: _____ DOB: _____

REVIEW OF SYSTEMS: Check the problems you are experiencing. If no problems exist, check NONE

GENERAL	__ None	__ fever	__ weight loss	__ weight gain
	__ chills	__ night sweats	__ fatigue	__ poor sleep
SKIN	__ NONE	__ rash	__ itching	__ photosensitivity
__ open wounds/sores		__ nodules	__ hair loss	__ insect bites
EYES	__ NONE	__ visual loss	__ dry eyes	__ red eyes
EARS	__ NONE	__ hearing loss	__ ear pain	__ ringing in ears
NOSE	__ NONE	__ sinus pain	__ runny nose	__ nosebleeds
THROAT	__ NONE	__ sore throat	__ cough	__ difficulty swallowing
MOUTH	__ NONE	__ dry mouth	__ sores in mouth	__ tooth loss
CARDIOVASCULAR		__ NONE	__ chest pain	__ palpitations
__ abnormal valve		__ abnormal beat	__ poor circulation	__ leg swelling
RESPIRATORY		__ NONE	__ shortness of breath	__ cough
__ pneumonia		__ bronchitis	__ sputum production	__ asthma
GASTROINTESTINAL		__ NONE	__ abdominal pain	__nausea
__ heartburn		__ vomiting	__ constipation	__ diarrhea
__ loss of appetite		__jaundice	__ gallstones	__ black tarry stools
ENDOCRINE		__ NONE	__ high blood sugar	__ increased appetite
__ heat tolerance		__ cold intolerance	__ increased thirst	__ frequent urination
__ menopausal symptoms				
GENITOURINARY		__ NONE	__ painful urination	__ difficult urination
__ blood in urine		__ kidney stones	__ recurrent infection	__ irregular periods
__ heavy periods		__ possible pregnancy	__ renal failure/insufficiency	
HEMATOLOGIC/LYMPHATIC			__ NONE	__ anemia
__ low white cells/platelets		__ swollen glands	__ easy bruising	__ recurrent bleeding
ALLERGIC/IMMUNOLOGIC		__ NONE	__ frequent infection	__ allergies
NEURO/PHYCH		__ NONE	__ headache	__ muscle weakness
__ seizures		__ fainting spells	__ dizziness	__ numbness/tingling
__ memory loss		__ poor concentration	__ anxiety	__ depression
MUSCULOSKELETAL		__ NONE	__ neck pain	__ back pain
__ trouble walking		__ bone fractures	__ accident trauma	__ muscle cramps
__morning stiffness		__ joint pain and swelling (list joints involved): _____		

PLEASE USE THE SPACE BELOW TO PROVIDE ANY ADDITIONAL INFORMATION: _____

PROVIDER SIGNATURE _____ PATIENT SIGNATURE _____ DATE _____

Health Assessment Questionnaire

STANFORD UNIVERSITY SCHOOL OF MEDICINE, DIVISION OF IMMUNOLOGY AND RHEUMATOLOGY

Name_____ Date_____

This questionnaire is designed to help us assess how your illness affects your ability to function in daily life. Please feel free to add any additional comments on the back of this page.

Please mark "x" in the response that best describes your usual abilities OVER THE PAST WEEK:

	Without ANY difficulty (0)	With SOME difficulty (1)	With MUCH difficulty (2)	Unable to do (3)
DRESSING AND GROOMING				
Are you able to: –Dress yourself, including tying shoelaces and doing buttons?	○	○	○	○
–Shampoo your hair?	○	○	○	○
ARISING				
Are you able to: –Stand up from a straight chair?	○	○	○	○
–Get in and out of bed?	○	○	○	○
EATING				
Are you able to: –Cut your meat?	○	○	○	○
–Lift a full cup or glass to your mouth?	○	○	○	○
–Open a new milk carton?	○	○	○	○
WALKING				
Are you able to: –Walk outdoors on flat ground?	○	○	○	○
–Climb up five steps?	○	○	○	○

Please mark "x" in any AIDS or DEVICES that you usually use for any of these activities:

- ○ Cane
- ○ Walker
- ○ Crutches
- ○ Wheelchair
- ○ Devices used for dressing (button hook, zipper pull, long shoe horn, etc.)
- ○ Built-up or special utensils
- ○ Special or built-up chair
- ○ Other (Specify): _____

Please mark "x" in any categories for which you usually need HELP FROM ANOTHER PERSON:

○ Dressing and grooming ○ Arising ○ Eating ○ Walking

Continued on other side

Please mark "x" in the response that best describes your usual abilities OVER THE PAST WEEK:

	Without ANY difficulty (0)	With SOME difficulty (1)	With MUCH difficulty (2)	Unable to do (3)
HYGIENE				
Are you able to: –Wash and dry your body?	○	○	○	○
–Take a tub bath?	○	○	○	○
–Get on and off the toilet?	○	○	○	○
REACH				
Are you able to: –Reach and get down a 5-pound object (such as a bag of sugar) from just above your head?	○	○	○	○
–Bend down to pick up clothing from the floor?	○	○	○	○
GRIP				
Are you able to: –Open car doors?	○	○	○	○
–Open jars which have been previously opened?	○	○	○	○
–Turn faucets on and off?	○	○	○	○
ACTIVITIES				
Are you able to: –Run errands and shop?	○	○	○	○
–Get in and out of a car?	○	○	○	○
–Do chores such as vacuuming or yardwork?	○	○	○	○

Please mark "x" in any AIDS OR DEVICES that you usually use for any of these activities:

○ Raised toilet seat ○ Bathtub bar ○ Other (Specify): _____

○ Bathtub seat ○ Long-handled appliances for reach

○ Jar opener (for jars previously opened) ○ Long-handled appliances in bathroom

Please mark "x" in any categories for which you usually need HELP FROM ANOTHER PERSON:

○ Hygiene ○ Reach ○ Gripping and opening things ○ Errands and chores

We are also interested in learning whether or not you are affected by pain because of your illness.

How much pain have you had because of your illness IN THE PAST WEEK:

NO PAIN	SEVERE PAIN
0	100

PLACE A VERTICAL (|) MARK ON THE LINE TO INDICATE THE SEVERITY OF THE PAIN

FAMILY ARTHRITIS CENTER/AARA

NOTICE OF PRESCRIPTION POLICY CHANGE:

For your convenience, we will only be giving written prescriptions for all controlled medications. This will prevent patients need to wait for refills and repeated calls to the office. Please be sure to ask your provider for any prescription refills or changes to medications in the exam room, during your office visit. It is your responsibility to know which medications you are out of and/or need refills of. Any prescriptions which are not received during your visit will need to be picked up from our office in person and taken to your pharmacy.

Lost, misplaced, or stolen narcotic prescriptions will not be replaced under any circumstances as per our office policy.

Patient Signature:_____

Patient Name (Please Print):_____

Date:_____

Witness Signature:_____Date:_____

FAMILY ARTHRITIS CENTER

PATIENT REFERRAL AND FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Family Arthritis Center as your healthcare provider. We are honored by your choice and committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient referral and financial policies, which are as follows:

• The patient is ultimately responsible for obtaining the **referral** from their primary doctor if required by their insurance company and providing it before or at the time of visit.

• The patient is responsible for charges associated with Insurance **co-pays, deductibles, co-insurance** and/or non-covered charges.

• The patient is ultimately responsible for the payment of his/her treatment and care if a referral is **not** provided as requested and your claim is being denied or your insurance plan is not valid.

• The patient is responsible for all balances on their account and all fees associated with collection action if patient fails to pay PLUS 1.5% interest.

• The patient is aware that failure to pay for his/her treatment and care will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency).

• We reserve your appointment time especially for you. A 24-hour notice of rescheduling or cancellation is REQUIRED. We reserve the right to charge you for a NO SHOW or CANCELLED appointment the same day of the visit. This charge will be **$50** for a follow-up appointment, DEXA, injection, or infusion; and **$100** for a New Patient appointment. We are aware that emergencies can arise, but repeated cancellations and no shows will result in DISMISSAL from the practice. Confirmations are a COURTESY; therefore, you are expected to remember your appointments.

• By my signature below, I hereby authorize assignment of financial benefits directly to Family Arthritis Center and associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Referral and Financial Responsibility Form:

Signature of Patient or Guardian: _____Date: _____

Name of patient: _____

Waiver of Patient Authorizations:

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible of charges and to submit claims to my insurance company at my discretion.

Signature of Patient or Guardian: _____Date: _____

Name of patient: _____