Patient Information Sheet

Last Name: First Name: MI:

Address:

City: State: Zip Code:

Referring Provider: PCP: Sex (M/F) Marital Status: (S/M/D/W)

Date of Birth: Social Security #:

Home Phone: Work Phone:

Email: Cell Phone:

Emergency Contact: Contact Phone:

Primary Insurance Coverage

Company:

Insured Name:

Relationship: DOB:

Policy Number:

Group Number:

Employer

Secondary Insurance Coverage

Company:

Insured Name:

Relationship: DOB:

Policy Number:

Group Number

Employer:

Guarantor Information

Guarantor Name:

Address:

City: State: Zip Code:

Phone Number: Miscellaneous Information:

Patient Authorization

I authorize Rheumatology Associates of Delmarva to apply for benefits on my behalf for services rendered by Rheumatology Associates of Delmarva. I request payment from my insurance company be made directly to Rheumatology Associates of Delmarva. I certify that the information I have reported with regard to y insurance coverage is correct and further authorize the release of any necessary information including medical information for this or any related claims. I permit a copy of this authorization to be used in alee of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

Signature of Subscriber or Beneficiary

Date

Rheumatology Associates of Delmarva

Edmund J. MacLaughlin, M.D., FACR, CCD — Elizabeth S. Clayton, M.D., FACR — Naila B. Ahmad, M.D., FACR

Curtis M. Foy, M.D., CCD — Catherine G. Campbell, P.A.-C., MMS — Meghan B. McCarter, FNP-BC

Rheumatology & Osteoporosis Management

Patient History Form

Date of first appointment: ____/____/____ (MONTH / DAY / YEAR) Time of appointment: _____ Birthplace: _____

Name: _____ (LAST / FIRST / MIDDLE INITIAL / MAIDEN) Birthdate: ____/____/____ (MONTH / DAY / YEAR)

Address: _____ (STREET / APT#) Age: _____ Sex: ❑ F ❑ M

_____ (CITY / STATE / ZIP) Telephone: Home (____) _____ Work (____) _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses _____

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/average per week _____

Referred here by: (check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: _____

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

Do you have an orthopedic surgeon? ❑ Yes ❑ No If yes, Name: _____

Describe briefly your present symptoms: _____

_____

_____

_____

Date symptoms began (approximate): _____

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

_____

_____

_____

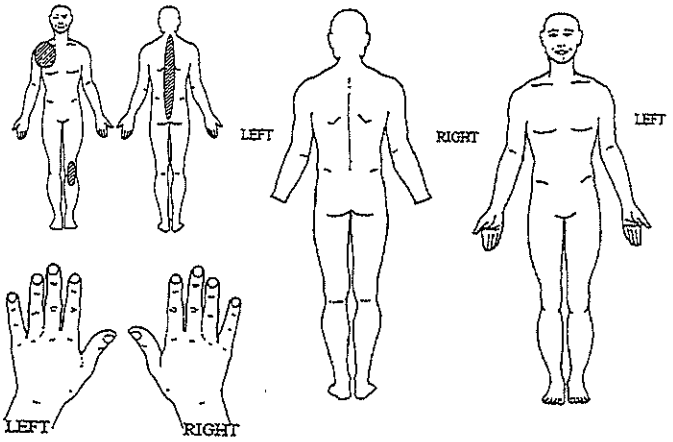
Please list the names of other practitioners you have seen for this problem:

_____

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram ____/____/____ Date of last eye exam ____/____/____ Date of last chest x-ray ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- ❑ Recent weight gain
  amount _____
- ❑ Recent weight loss
  amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears–Nose–Mouth–Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing

Cardiovascular

- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began:_____

Periods regular? ❑ Yes ❑ No

How many days apart? _____

Date of last period? ____/____/____

Date of last pap?____/____/____

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ❑ Morning stiffness
  Lasting how long?
  _____ Minutes _____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

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

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

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SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago? _____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

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

_____

Do you exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

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

Do you wake up feeling rested? ❑ Yes ❑ No

PAST MEDICAL HISTORY

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

❑ Cancer	❑ Heart problems	❑ Asthma
❑ Goiter	❑ Leukemia	❑ Stroke
❑ Cataracts	❑ Diabetes	❑ Epilepsy
❑ Nervous breakdown	❑ Stomach ulcers	❑ Rheumatic fever
❑ Bad headaches	❑ Jaundice	❑ Colitis
❑ Kidney disease	❑ Pneumonia	❑ Psoriasis
❑ Anemia	❑ HIV/AIDS	❑ High Blood Pressure
❑ Emphysema	❑ Glaucoma	❑ Tuberculosis

Other significant illness (please list) _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

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: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

_____

Do you know of any blood relative who has or had: (check and give relationship)

❑ Cancer _____	❑ Heart disease _____	❑ Rheumatic fever _____	❑ Tuberculosis _____
❑ Leukemia _____	❑ High blood pressure _____	❑ Epilepsy _____	❑ Diabetes _____
❑ Stroke _____	❑ Bleeding tendency _____	❑ Asthma _____	❑ Goiter _____
❑ Colitis _____	❑ Alcoholism _____	❑ Psoriasis _____	

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MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? _____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Pharmacy: _____ List Medications / Supplements Taken	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

PAST MEDICATIONS 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/Dosage	Length of Use	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		☐	☐	☐	
Circle any you have taken in the past Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)		☐	☐	☐	
Codeine (Vicodin, Tylenol 3)		☐	☐	☐	
Propoxyphene (Darvon/Darvocet)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		☐	☐	☐	
Gold shots (Myochrysine or Solganol)		☐	☐	☐	
Hydroxychloroquine (Plaquenil)		☐	☐	☐	
Penicillamine (Cuprimine or Depen)		☐	☐	☐	
Methotrexate (Rheumatrex)		☐	☐	☐	
Azathioprine (Imuran)		☐	☐	☐	
Sulfasalazine (Azulfidine)		☐	☐	☐	
Quinacrine (Atabrine)		☐	☐	☐	
Cyclophosphamide (Cytoxan)		☐	☐	☐	
Cyclosporine A (Sandimmune or Neoral)		☐	☐	☐	
Etanercept (Enbrel)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Prosorba Column		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	

PAST MEDICATIONS Continued

	Length of Use	Please check: Helped? A Lot	Some	Not At All	Reactions
Osteoporosis Medications					
Estrogen (Premarin, etc.)		❑	❑	❑	
Alendronate (Fosamax)		❑	❑	❑	
Etidronate (Didronel)		❑	❑	❑	
Raloxifene (Evista)		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal (Miacalcin, Calcimar)		❑	❑	❑	
Risedronate (Actonel)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid (Benemid)		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol (Zyloprim/Lopurin)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen (Nolvadex)		❑	❑	❑	
Tiludronate (Skelid)		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyalgan/Synvisc injections		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	
Please list supplements:					

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list:

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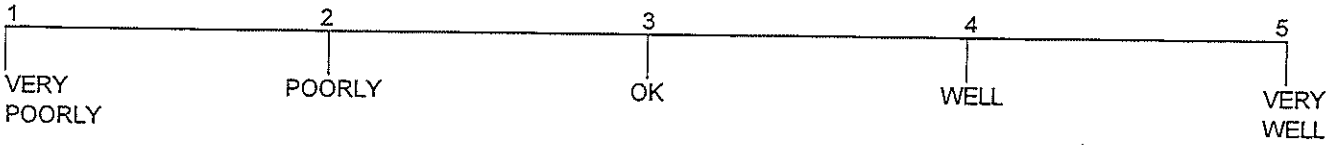
ACTIVITIES OF DAILY LIVING

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

How many people in household? _____ Relationship and age of each _____

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

On the scale below, circle a number which best describes your situation; *Most of the time, I function...*



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, toothbrush, pencil, etc.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from 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 family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness?	❑	❑	❑
Do you use a cane, crutches, as walker or a wheelchair? (circle one)	❑	❑	❑

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 ❑

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Meaningful Use Information

Due to changing healthcare laws, we are required to collect more patient demographic information

Last Name: _____

First Name: _____

Email Address: _____

Preferred Language: _____

Race
(Circle One)

American Indian

Asian

Black

Native Hawaiian

White

Declined to Answer

Ethnicity
(Circle One)

Hispanic Origin

Non-Hispanic Origin

Decline to Answer

Smoking Status
(Circle One)

Never Smoker

Current every day smoker
Start Date:

Current some day smoker
Start Date:

Heavy tobacco smoker
Start Date:

Light tobacco smoker
Start Date:

Smoker, current status unknown

Unknown if every smoked

Former Smoker
Start Date: End Date:

Preferred Pharmacy: _____

Pharmacy Address: _____

Pharmacy Phone/Fax: _____

I agree that Edmund J. MacLaughlin, M.D. May request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

Patient Signature: X _____ **Date: X** _____

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PATIENT ACKNOWLEDGEMENT OF NON-COVERED SERVICES

Patient Name:_____ Date of Birth:_____

Medicare#:_____ Referring Provider:_____

Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862(s) (1) of the Medicare law. Your provider is in the best position to know the clinical assessment needs of his or her patients. In some cases, when your provider orders a specific test to detect pre-symptomatic diseases or, as part of a process to help determine what the diagnosis is, some insurers, including Medicare, will not pay for the test performed. In your case, you have been notified that Medicare may deny payment for the services indicated because Medicare usually does not pay for: a) This test for the reported condition; b) For non-FDA approved tests or c) For tests ordered for screening purposes.

By signing below, IF Medicare denies payment, you agree to be FULLY responsible for payment.

TO BE SIGNED BY THE PATIENT:

"I HAVE BEEN NOTIFIED THAT, IN MY CASE, Medicare may deny payment for the services. If Medicare denies payment, I agree to be responsible for payment. I understand that if the claim is denied, I will receive a bill from Rheumatology Associates of Delmarva for the denied services."

Signed: _____ Date:_____

Witness: _____

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Financial Policy

We believe that everyone benefits when there is a definite and clear financial agreement prior to treatment. Our policy is as follows:

If applicable, your insurance co-pay is due upon service. Co-pays will be collected at the time of check-in.

Please understand that a referral from your family doctor may be necessary in order to submit claims to your insurance carrier. It is the **patient's responsibility** to obtain this referral. If a valid referral is not on file, then your appointment will have to be rescheduled.

There are a certain number of appointments available each day and often patients who are sick cannot be seen the same day that they call. With this in mind, if you are unable to keep a scheduled appointment, we require 24 hours' notice, so that we may schedule another patient into your appointment slot. If the required notice is not given, then a cancellation charge of $50.00 for new patients and $25.00 for established patients will be assessed to the patient, not billed to any insurance company. Until this fee is paid, another appointment will not be scheduled.

All accounts with a balance over 30 days will be assessed a 1.5% late charge per month on the unpaid monthly balance. Payment plans can be arranged through the Billing Manager (410-819-6630). If an account becomes assigned to a collection agency, the patient will pay 25% of the collection agency fees, 100% of court costs and 100% of attorney fees.

I hereby certify that I have read and understand the above and agree with all terms and conditions. I also authorize the release of any personal health information to my insurance company and another other health care professionals involved in my care.

Signed_____ Date_____

Printed Name_____

Witness_____

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NO SHOW POLICY

If you are unable to keep your scheduled appointment for any reason, please notify the office at least 24 hours in advance so that we can accommodate other patients who may need to be seen.

Our "NO SHOW" policy is as follows:

1. After the first "NO SHOW" appointment, you will receive a phone call as to why the appointment was missed and to reschedule.

2. After the "second" missed appointment, you will be charged $25.00 for the time slot that we were not able to fill.

3. After the "third" missed appointment, you may be discharged from the practice; giving you 30 days to find a new physician.

Patient Signature _____

Date _____

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Patient Authorization to Receive/Release Health Information

Due to the HIPAA Compliance Privacy Laws of the Federal Government, it is mandatory that we ask you to review and answer the following questions listed below.

Patient Name: _____

Date of Birth: _____ Social Security #: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

Specific description of the information to be used/disclosed:

Any records pertaining to the diagnosis and treatment of the rheumatologic conditions for which I am being seen.

Persons authorized to use or disclose the above "authorized information":

Rheumatology Associates of Delmarva employees

Person's to whom the use or disclosure of the authorized information may be made: Affiliated hospitals providing care for the above named patient, other physicians providing care for the patient, the patient's pharmacy, insurance companies, and in some cases, we may need to provide information to our accountant and/or lawyer.

We may leave messages/ detailed medical information on voicemail at either of these phone numbers?

Home Phone: _____ Yes ___ No ___ Cell Phone: _____ Yes: ___ No: ___

May we contact your place of employment? Yes ____ No ____

If so, may we leave a message? Yes ____ No ____

If yes: Work Phone: _____ Ext.: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, billing)?

Yes _____ No _____ **If yes, please provide:**

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? Yes _____ No _____

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? Yes _____ No _____

TURN OVER—COMPLETE BACK SIDE

Patient's Name: _____

- *I understand that if the person or entity receiving the authorized information listed above is not a health plan or health care provider covered by the federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.*

- *I understand that I may revoke this authorization at any time by notifying Rheumatology Associates of Delmarva in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Rheumatology Associates of Delmarva prior to receiving my revocation.*

I hereby authorize Rheumatology Associates of Delmarva to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed the aforementioned information and provide my consent regarding any and all issues as stated above.

I have reviewed the Rheumatology Associates of Delmarva Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Signed by: _____ _____

Signature of Patient or Personal Representative — Relationship to Patient

_____ _____

Printed Name of Personal Representative — Date

Witnessed by: _____ _____

Signature — Date

_____

Printed Name

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION