



ARTHRITIS & RHEUMATOLOGY ASSOCIATES
of Palm Beach

Boynton Beach location: 6056 Boynton Beach Blvd Suite 145, Boynton Beach FL 33437
Phone (561) 439-1800 Fax (561) 439-4874

Date: _____

Acct: _____

Patient Name: Last _____ First _____ MI _____

Street Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Number _____ Mobile Phone # _____ Northern Phone # _____

Date of Birth _____ Age _____ Sex M/F _____ Social Security # _____ Marital Status S/M/D/W _____

Northern Address, If Applicable _____ City _____ State _____ Zip _____

Spouse's Name _____ Spouse's Date of Birth _____ Spouse's Social Security # _____

Parent's Name (if minor) _____ Daytime Phone # _____ Mobile Phone # _____

Primary Care Physician _____ Occupation _____

Referred by: _____ Emergency Contact (Name & Phone #) _____

Yes No

Insurance Name (e.g. Medicare, BCBS of FLA, United) _____ HMO _____

INSURANCE - A COPY OF YOUR CARD WILL BE ATTACHED TO THIS FORM

Please read and sign the following:

1. Payment for services is expected at time of visit.
2. If insurance is filed, I authorize benefits to be paid directly to Arthritis & Rheumatology Associates of Palm Beach.
3. I am responsible for the balance on my account, regardless of insurance coverage.
4. _____ initial I authorize Arthritis & Rheumatology Associates of Palm Beach, to release information requested with regard to the processing of my claims.
5. _____ initial I authorize laboratory / test information results / appointments to be left on my home phone answering machine.
6. _____ initial I authorize Laboratory / test information to be discussed with my spouse, or another family member.

Patient or Legal Guardian Signature _____ Today's Date _____

Please Print Name of signature above.



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MICHAEL SCHWEITZ, M.D. • JONATHAN GREER, M.D. • AMIEL TOKAYER, M.D. • RUI CEREJO, D.O.
MARICARMEN QUINTERO, M.D. • PAUL MENDOZA, M.D. • CATHERINE GARCIA, M.D. • ANDREW VASCONCELLOS, M.D.

Specializing In Arthritis & Rheumatic Diseases

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

Name _____ Birthdate ____/____/____
LAST FIRST MIDDLE INITIAL MONTH DAY YEAR

Address _____ Age: _____ Sex ____ F ____ M
STREET APT #
CITY STATE ZIP Telephone: Home () _____
Work () _____

Race: _____ Ethnicity: Hispanic or Latino ____ Yes ____ No. If yes, origin: _____

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

Name of person making referral _____

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

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 and injections: medication to be listed later)

Please list the name 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")

| Yourselves | Relative (name/relationship) | Yourselves | Relative (name/relationship) |
|--------------------------------|------------------------------|------------------------------|------------------------------|
| _____ Arthritis (type unknown) | _____ | _____ Lupus or "SLE" | _____ |
| _____ Osteoarthritis | _____ | _____ Ankylosing spondylitis | _____ |
| _____ Rheumatoid Arthritis | _____ | _____ Childhood arthritis | _____ |
| _____ Gout | _____ | _____ Osteoporosis | _____ |

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Other arthritis conditions: _____

PAST PERSONAL HISTORY

Do you or have you 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 _____ | Breast Prosthesis _____ |

Other Significant Illness (please list): _____

Do you smoke? ____ Yes ____ No If no, are you a former smoker? ____ Yes ____ No

Previous Operations:

| Type | Year | Surgeon |
|----------|-------|---------|
| 1) _____ | _____ | _____ |
| 2) _____ | _____ | _____ |
| 3) _____ | _____ | _____ |
| 4) _____ | _____ | _____ |
| 5) _____ | _____ | _____ |
| 6) _____ | _____ | _____ |
| 7) _____ | _____ | _____ |

Any previous fractures? No Yes, describe: _____

Any other serious injuries? No Yes, describe: _____

Medication Allergies and Type of Reaction(s)? _____

FAMILY HISTORY:

| | If living | | If deceased | |
|--------|-----------|--------|--------------|-------|
| | Age | Health | Age of death | Cause |
| Father | | | | |
| Mother | | | | |

Number of Brothers _____ Number Living _____ Number Deceased _____

Number of Sisters _____ Number Living _____ Number Deceased _____

Number of Children _____ Number Living _____ Number Deceased _____ List ages of each _____

Serious illness of children _____

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

| | | | |
|----------------|---------------------------|-----------------------|----------------|
| Cancer _____ | Heart Disease _____ | Rheumatic fever _____ | Diabetes _____ |
| Leukemia _____ | High Blood Pressure _____ | Epilepsy _____ | Goiter _____ |
| Stroke _____ | Bleeding tendency _____ | Asthma _____ | |
| Colitis _____ | Alcoholism _____ | Tuberculosis _____ | |

MARITAL STATUS:

____ Never Married ____ Married ____ Divorced ____ Separated

Spouse ____ Alive/Age _____ ____ Deceased/Age _____ Major Illness _____

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Present: (List any medications you are taking at this time. Include items such as aspirin, vitamins, laxatives, calcium supplements, etc.)

| Name of Drug | Dose (Include strength and 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. | | | | | |
| 11. | | | | | |
| 12. | | | | | |

Past: 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 Time | Results | | | Reactions |
|-------------------------------|----------------|---------|------|------------|-----------|
| | | A lot | Some | Not at all | |
| 1. Aspirin | | | | | |
| 2. Aspirin-containing product | | | | | |
| 3. Easprin | | | | | |
| 4. Disacid | | | | | |
| 5. Tylenol (pain) | | | | | |
| 6. Tylenol with codeine | | | | | |
| 7. Darvon/Darvocet | | | | | |
| 8. Cilnoril | | | | | |
| 9. Feldene | | | | | |
| 10. Indocin | | | | | |
| 11. Meclomen | | | | | |
| 12. Motrin/Rufen | | | | | |
| 13. Naifon | | | | | |
| 14. Naprosyn | | | | | |
| 15. Tolectin | | | | | |
| 16. Cortisone/Prednisone | | | | | |
| 17. Benemid | | | | | |
| 18. Colchicine | | | | | |
| 19. Zylprim/Lopurin | | | | | |
| 20. Gold (Shots or Pills) | | | | | |
| 21. Plaquenil | | | | | |
| 22. Penicillamine | | | | | |
| 23. Methotrexate | | | | | |
| 24. Imuran | | | | | |
| 25. Cytoxan | | | | | |
| 26. Other | | | | | |
| 27. Other | | | | | |
| 28. Other | | | | | |

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To our patients,

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to an address other than your home address.

The physicians and staff of the Arthritis & Rheumatology Associates of Palm Beach respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind, please indicate your preferences for the areas noted below.

I wish to be contacted in the following manner (check ALL that apply):

- Home/Cell Telephone _____
 - Leave message with **detailed** information
 - Leave message **ONLY** with call back number
- Work Telephone _____
 - Leave message with **detailed** information
 - Leave message **ONLY** with call back number
- Written Communications
 - Mail to my home address
 - Mail to my work/office address
 - Fax to this number: _____

You may speak with the following individuals (spouse, family, caretakers, etc.) regarding:

- My care or treatment (blood results, etc.)
- My bills
- My appointments
- Prescriptions (**giving permission to pick up medicine scripts as well*)

| Name | Relationship |
|-------|--------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I understand that I may revoke this authorization at any time with written notification to Arthritis & Rheumatology Associates of Palm Beach.

| | |
|--------------------|---------------|
| _____ | _____ |
| Print Patient Name | Date of birth |
| _____ | _____ |
| Patient Signature | Date |



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Patient Name: _____

Date of Birth: _____ Social Security #: _____

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices, which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we must try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

I have received the Notice of Privacy Practices (effective date September 23, 2013)

Patient's (or Legal Representative's Signature)

Date

Relationship of Legal Representative

For office use only

To be completed only if Acknowledgment is not signed.

1) Was the patient given a copy of the Notice of Privacy Practices?

Yes No

2) Please explain why the patient was unable to sign this Acknowledgment and our efforts to try to obtain the patient's signature:

Name/Title

Date

Place completed Acknowledgment in patient's medical record.

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NO SHOW POLICY

In an effort to address this concern and continue to meet the needs of our patients, we have developed the following No Show Policy.

1. To cancel an appointment, we require advance notice of 48 hours.
2. For appointments canceled in 24 hours or less, or for missing an appointment, a fee of \$25 will be levied to cover administrative expenses.
3. Patients who do not schedule within 30 days or have a history of repeatedly not showing may be subject to dismissal for “non-compliance.”

Patient Signature Date

INSURANCE HOLDER, CO-PAY & REFERRAL POLICY

It is the patient’s responsibility to be aware of their insurance co-pay amount and referral requirements. All co-payments are to be made at the time of visit. The patient is responsible to bring or confirm with the office that a referral is on file prior to scheduled appointment, if it is required. Failure to cooperate may result in the appointment being rescheduled.

Patient Signature Date

Insurance Holder: Self (Patient) Other (Please fill out the following)

Name of Insurance Holder: _____

Relationship to Patient: _____

Date of Birth: _____

Social Security Number: _____

Insurance Company: _____

Policy #: _____

RETURN CHECK POLICY

If a patient’s check is returned by the bank, the patient will be charged a fee of \$25.00 and will no longer be allowed to make payments with checks.

Patient Signature Date

PHARMACY INFORMATION

Name of your pharmacy: _____

Pharmacy phone #: _____



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Attention All Patients

Our practice is using www.NextMD.com Patient Portal. You will be able to access some of your electronic chart as well communicate with your doctor's staff. By giving us your e-mail address, an account will be created and you will be given an **enrollment token**. An e-mail will then be sent to you containing a link to the patient portal to complete your account set-up.

Please do **not** reply to the e-mail; all messages for the staff and/or doctor must be sent through the patient portal, after you have completed your account set-up.

Signing this form and releasing your e-mail address gives our Practice authorization to create your personal online account. You will be able to view your demographic information on file, allergies, problems/diagnoses, medications, vital signs recorded during your appointments, lab results, and any educational literature given by the doctor(s). You will also have the ability to request appointments and contact the staff.

You should **not** use your Patient Portal for emergencies. If your condition is serious, a visit to the Emergency Room may be your best choice for treatment, dial 911 if you need immediate assistance. By utilizing Arthritis and Rheumatology Associates of Palm Beach's Patient Portal you acknowledge that you will not receive immediate responses to questions, medical requests, medication requests, or appointment requests. Arthritis And Rheumatology Associates of Palm Beach is not responsible for illness or injury from your choice to not seek emergency treatment.

I authorize Arthritis and Rheumatology Associates of Palm Beach to create a patient portal account.

Email: _____

I decline this service and understand I may contact the office at any time if I change my decision.

Signature

Date

Patient's Name (Print)

Date of Birth