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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Specializing In Arthritis & Rheumatic Diseases

Name _____ Date: _____/_____/_____
FIRST MIDDLE INITIAL LAST MONTH DAY YEAR

Birthdate _____/_____/_____ Birthplace:_____
MONTH DAY YEAR

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: _____

What is the main reason for today's visit?:

_____

_____

_____

Date symptoms began (approximate) _____

Diagnosis given? (Please list)

_____

_____

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

_____

_____

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

_____

_____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourself		Relative (name/relationship)	Yourself		Relative (name/relationship)
_____	Arthritis (type unknown)	_____	_____	Lupus or "SLE"	_____
_____	Osteoarthritis	_____	_____	Ankylosing spondylitis	_____
_____	Rheumatoid Arthritis	_____	_____	Childhood arthritis	_____
_____	Gout	_____	_____	Osteoporosis	_____
_____	Psoriatic Arthritis	_____	_____	Rheumatic Fever	_____
_____	Colitis (Crohn's Disease)	_____			

Other arthritis conditions:_____

PAST MEDICAL HISTORY & REVIEW OF SYSTEM

Please check if you have a history of or currently have any of the following:

Skin Problems	___	Difficulty Swallowing	___	Irregular Heartbeat	___	Visual Problems	___
Rashes	___	Dry Mouth	___	High Blood Pressure	___	Glaucoma	___
Hives	___	Oral Sores	___	High Cholesterol	___	Blindness	___
Eczema	___	Throat Problems	___	Chest Pain	___	Cataracts	___
Psoriasis	___	Shortness of Breath	___	Heart Problems	___	Dry Eyes	___
Nail Changes	___	COPD/Asthma	___	Heart Murmur	___	Frequent Headaches	___
Balding/Hair loss	___	Frequent Cough	___	Heart Attack	___	Migraines/Headaches	___
Sensitivity to the Sun	___	Emphysema	___	Swelling of Legs	___	Dizziness	___
Cancer	___	Bronchitis	___	Fainting Spells	___	Vertigo	___
Leukemia	___	Cough Up Blood	___	Indigestion	___	Stroke	___
Blood Clots	___	Blood in Phlegm	___	Stomach ulcers	___	Memory Problems	___
Miscarriages	___	Pneumonia	___	Poor Appetite	___	Kidney Stones	___
Bleeding Problems	___	Frequent Colds	___	Abdominal Cramps	___	Kidney Disease	___
Easy Bruising	___	Sinus Infections	___	Rectal Bleeding	___	Diabetes	___
Anemia	___	Impaired Hearing	___	Hemorrhoids	___	Urine Sugar	___
Blood Transfusions	___	Freq Ear Infections	___	Unintentional Weight Loss	___	Freq. Kidney Infection	___
Tumors	___	Ear Swelling	___	Recent Weight Gain	___	Freq. Bladder infection	___
Shingles	___	Psychiatric Illness	___	Hernia	___	Protein in Urine	___
Tuberculosis	___	Breast Implants	___	Jaundice	___	Blood in Urine	___
Hepatitis	___	Tingling	___	Weak Muscles	___	Frequent Urination	___
Gonorrhea/Chlamydia	___	Numbness	___	Muscle Pain	___	Genital Sores	___
Masses or Lumps	___	Arthritis	___	Convulsions/Seizures	___	Menstrual Problems	___
Where? _____		Insomnia	___	Shock	___	Last Menstrual Period_____	
Fevers	___	Sleep apnea	___	Epilepsy	___	Fatigue	___
Chills	___	Night Sweats	___	Nervousness	___	Depression	___
Blue/Red Discoloration in Fingers with Cold Exposure	___						

PAST SURGICAL HISTORY

PLEASE LIST ALL SURGERIES YOU HAVE HAD BELOW:

TYPE: _____ AGE: _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

DR. GARCIA

6056 BOYNTON BEACH BLVD SUITE 145, BOYNTON BEACH, FL 33437 | 561.439-1800 | (F)561.439.4874

MEDICATIONS

LIST **ALL** CURRENT PRESCRIPTIONS/VITAMINS/OVER-THE-COUNTER MEDS:

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

ALLERGIES TO MEDS? YES _____ NO _____ LATEX ALLERGY? YES _____ NO _____

IF YES, LIST MEDICATIONS WITH TYPE OF REACTION: _____

_____

Do you drink alcoholic beverages? _____ Yes _____ No If yes, how many drinks per week? _____

Do you smoke? _____ Yes _____ No _____ Former smoker If yes/former smoker, how many packs per day? ___

MARITAL STATUS:

_____ Never Married _____ Married _____ Divorced _____Separated

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

_____

OCCUPATION: _____

FAMILY HISTORY:

	If living		If deceased	
	Age	Health	Age of death	Cause
Father				
Mother				
Sibling				
Sibling				
Sibling				

Please return to front desk when completed. Thank you!! ☺

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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

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