



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.



ARTHRITIS & RHEUMATOLOGY ASSOCIATES
Of Palm Beach

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

Name (Nombre): _____ Date (Fecha): _____

Last (Apellido) First Middle Initial

Country of origin (país de origen): _____ Ethnicity (etnia): Hispanic/Latino ___ Yes (Sí) ___ No

What is your primary language? (¿Cual es su idioma de preferencia?) _____

Referring physician (Médico que le refiere): _____

Reason for today's visit (Razón de su visita): _____

Previous treatment for this problem (Tratamientos previos para este problema):

Please list all surgeries you have had (Favor de mencionar todas las operaciones que haya tenido:

_____	Age (Edad): _____
_____	Age (Edad): _____
_____	Age (Edad): _____
_____	Age (Edad): _____

Medications and doses (Medicinas y dosis):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medicine? (¿Es alérgico a algún medicamento?) _____

If you smoke, how many cigarettes/packs per day do you smoke and for how many years have you been smoking? (Si fuma, cuántos cigarros/cajas al día fuma Ud. Y por cuántos años ah fumado?)

If you stopped smoking, how many cigarettes/packs per day did you smoke and how long ago did you stop? (Si fumaba antes, cuántos cigarros/cajas al día fumaba Ud. Y hace cuánto tiempo ha dejado de fumar?)

If you drink alcoholic beverages, how many do you drink per week? (Si toma bebidas alcoholicas, cuántas toma a la semana?) _____

DR. QUINTERO

Boynton Beach location: 6056 Boynton Beach Blvd Suite 145, Boynton Beach, FL 33437

Phone (561) 439-1800 Fax (561) 439-4874

In the present or in the past, have you or a blood relative had any of the following?
(Padece o padeció Ud. o alguien de su familia inmediata, algunas de las siguientes enfermedades?)

	Yourself (Usted)	Relative/relationship (familiar/relación)
Rheumatoid Arthritis (Artritis reumatoidea)	_____	_____
Osteoarthritis (Osteoartritis)	_____	_____
Gout (Gota)	_____	_____
Lupus or "SLE" (lupus)	_____	_____
Ankylosing Spondylitis (espondilitis anquilosante)	_____	_____
Psoriasis (psoriasis)	_____	_____
Colitis (colitis)	_____	_____
Childhood Arthritis (arthritis infantil)	_____	_____
Osteoporosis	_____	_____
Cancer	_____	_____

Do you have any of the following (¿Tiene Ud. alguno de los siguientes síntomas?)

_____ Weight loss/gain (aumento o pérdida de peso)	_____ Tingling (hormigueo)
_____ Fatigue (fatiga)	_____ Muscle pain (dolor muscular)
_____ Poor appetite (poco apetito)	_____ Cough (tos)
_____ Weakness (debilidad)	_____ Shortness of breath (falta de aire)
_____ Fever (fiebre)	_____ Chest pain (dolor de pecho)
_____ Headache (dolor de cabeza)	_____ Palpitations (palpitaciones)
_____ Visual problems (problemas con la vista)	_____ Leg swelling (hinchazón de las piernas)
_____ Hearing problems (problemas de audición)	_____ Dry eyes (ojos secos)
_____ Vertigo/dizziness (vertigo/mareo)	_____ Dry mouth (boca seca)
_____ Trouble swallowing (problemas al tragar)	_____ Sensitivity to the sun (sensitividad al sol)
_____ Nausea/vomiting (nauseas/vómitos)	_____ Mouth sores (úlceras en la boca)
_____ Abdominal pain (dolor abdominal)	_____ Hair loss (pérdida de pelo)
_____ Easy bruising (moretones)	_____ Morning stiffness (entumecimiento)
_____ Lumps (nódulos en el piel)	_____ Joint pain (dolor en las coyunturas)
_____ Numbness (adormecimiento)	_____ Skin rashes (erupciones en la piel)

Have you had any of the following (¿Ha tenido alguno de los siguientes síntomas?)

_____ Strokes (derrames cerebrales)	_____ Thyroid problems (problemas del tiroide)
_____ Seizures (convulsiones)	_____ Frequent colds (resfriados frecuentes)
_____ Frequent sinus infections (sinusitis frecuente)	_____ Asthma (asma)
_____ Frequent ear infections (infecciones de oído frecuente)	_____ Emphysema (enfisema)
_____ Heartburn (reflujo/hervedera)	_____ Cough up blood (toser sangre)
_____ Liver problems (problemas de hígado)	_____ Tuberculosis
_____ Hepatitis	_____ Bronchitis (bronquitis)
_____ Ulcers (úlceras)	_____ Heart disease (enfermedad del corazón)
_____ Rectal bleeding (sangrado rectal)	_____ High blood pressure (alta presión)
_____ Kidney stones (piedras en el riñón)	_____ Irregular heart beat (latidos del corazón irregular)
_____ Protein in urine (proteína en la orina)	_____ Insomnia (insomnio)
_____ Blood in urine (sangre en la orina)	_____ Depression (depresión)
_____ Anemia	_____ Anxiety (ansiedad)
_____ Blood transfusion (tranfusiones de sangre)	_____ Blood clots (coágulos de sangre)
_____ Diabetes	_____ Miscarriages (abortos)

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

DR. QUINTERO

Boynton Beach location: 6056 Boynton Beach Blvd Suite 145, Boynton Beach, FL 33437

Phone (561) 439-1800 Fax (561) 439-4874

Dr. Quintero's History & Physical

Name: _____ Date: _____

HPI:

PMH:

Wt _____

Ht _____"

B/P _____/_____

Pulse _____

Temp _____.

DR. QUINTERO

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



ARTHRITIS & RHEUMATOLOGY ASSOCIATES
Of Palm Beach

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

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



ARTHRITIS & RHEUMATOLOGY ASSOCIATES
Of Palm Beach

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

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.

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



ARTHRITIS & RHEUMATOLOGY ASSOCIATES
Of Palm Beach

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

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 #: _____

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



ARTHRITIS & RHEUMATOLOGY ASSOCIATES
Of Palm Beach

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

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