ARTHRITIS & RHEUMATOLOGY ASSOCIATES
of Palm Beach

1411 N Flagler Dr, Suite 5600
West Palm Beach, FL 33401
Ph(561) 659-4242 F(561) 659-5816

7108 Fairway Dr, Suite 300
Palm Beach Gardens, FL 33418
Ph(561)626-9696 F(561)626-2264

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: ____________

______________________________ ____________

______________________________ ____________

______________________________ ____________

______________________________ ____________

______________________________ ____________

______________________________ ____________

______________________________ ____________

______________________________ ____________

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______________________________ ____________

______________________________ ____________

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 **24 hours**.
2. For appointments **canceled the same day**, or for **missing an appointment**, a **fee of $50** will be levied to cover administrative expenses.
3. Patients who do not reschedule within 30 days or have a history of repeatedly not showing may be subject to dismissal for "non-compliance."
4. Patients who **arrive 15 minutes or so late must reschedule** their appointments.

______________________________ ____________________
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 has converted to Electronic Health Records (EHR). You will be able to access some of your electronic chart and contact medical staff *via* an online patient portal, **NextMD**. By giving us your e-mail address, an account will be created. An e-mail will then be sent to you containing a link to the patient portal and a "token" code 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 (once signed off by the physician), and any educational literature given by the doctor(s). You will also be able to send a message to the staff, request medication refills and follow-up appointments.

☐ I authorize Arthritis and Rheumatology Associates of Palm Beach to create an online account and to email me the account information for me to have limited access to my Electronic Health Record. I understand that the patient portal is not for emergencies and that I will not receive immediate responses. I acknowledge that Arthritis and Rheumatology Associates of Palm Beach is not responsible for any illness or injury from my choice not to seek emergency treatment.

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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