# LONG BEACH RHEUMATOLOGY NEW PATIENT FORM

**DATE**: _____/_____/_____

**NAME**: _____ **BIRTHDATE**: _____/_____/_____
**FIRST** **LAST** **M. I.**

**SEX:** ✈ F ✈ M

**ADDRESS:**

_____

**CELL PHONE:** _____ **HOME PHONE:** _____

**EMAIL:**_____

**EMERGENCY CONTACT: NAME**_____ **PHONE#**_____

**INSURANCE INFORMATION:**

**PRIMARY INSURANCE:** _____**ID#**_____

**SECONDARY INSURANCE:** _____**ID#**_____

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**PRIMARY OR REFERRING PHYSICIAN INFORMATION:**

**NAME:** _____ **PHONE#** _____

**ADDRESS:**_____

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**PHARMACY INFORMATION:**

**PHARMACY NAME/ADDRESS:**

_____

_____

**ZIP CODE:** _____ **PHONE#**_____**FAX#**_____

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**MEDICATIONS:**

**List only prescription medications, if there is more then 5 medications, please provide a printed list.**

| **Name of drug** | **Dose (include strength and number of pills per day)** |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**Drug allergies:** ✈ No ✈ Yes List: _____

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**MEDICAL HISTORY**

Check all that Apply:

| | | |
|---|---|---|
| ✈ Diabetes | ✈ Heart Problems | ✈ Crohn's disease |
| ✈ High blood pressure | ✈ Stroke | ✈ Colitis |
| ✈ High cholesterol | ✈ Seizures | ✈ Hepatitis |
| ✈ Hypothyroidism | ✈ Kidney disease | ✈ Jaundice |

✈ Cancer (type) _____

✈ Leukemia

✈ Psoriasis

**Other significant illnesses (please list):** _____

_____

_____

_____

_____

**FAMILY RHEUMATOLOGIC (ARTHRITIS) HISTORY**

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

| | Yourself | Relative | | Name/relationship |
|---|---|---|---|---|
| Arthritis (type unknown) | ✈ | ✈ | ☐ | |
| Osteoarthritis | ✈ | ✈ | ☐ | |
| Osteoporosis | ✈ | ✈ | ☐ | |
| Psoriasis/psoriatic arthritis | ✈ | ✈ | ☐ | |
| | ✈ | ✈ | ☐ | |
| Lupus or "SLE" | | | | |
| Ankylosing spondylitis | ✈ | ✈ | ☐ | |
| Gout | ✈ | ✈ | ☐ | |
| Sjogren's syndrome | ✈ | ✈ | ☐ | |

**SURGICAL HISTORY:**

| *Type* | *Year* | *Reason* |
|---|---|---|
| 1. | | |
| 2. | | |

**SMOKING/ DRINKING HISTORY:**

Do you smoke Cigarettes? ✈ Yes, __of packs a day ✈ No ✈ In the past - How long ago? _____

Do you smoke Marijuana? ✈ Yes for Pain ✈ Yes Recreational ✈ No

Do you drink alcohol? ✈ Yes Everyday Drinker ✈ Yes Social Drinker ✈ No

**Result of last TB (PPD) test: __Never Done __Negative __Positive Date: _____**

**Date of last Eye Exam: _____ Chest X-Ray: _____ Bone Density: _____**

**Review of Systems/ Symptoms:**

**Check all that Apply:**

**General**
__Recent weight gain
__Recent weight loss
__Fatigue
__Weakness
__Fever

**Muscle/Joint/Bones**
__Morning stiffness
__Joint Pain
__Joint Swelling
__Swollen Legs or feet
__Muscle Weakness

**Nervous System**
__Headaches
__Dizziness
__Fainting or loss of consciousness
__Numbness in Hands or Feet
__Tingling in Hands or Feet

**Skin**
__Easy Bruising
__Redness
__Hives
__Rash
__Nodules/bumps

**Kidney/Urine/Bladder**
__Difficult urination
__Pain in urination
__Burning in urination
__Blood in urine
__Cloudy urine

**Blood**
__Anemia
Other_____

**Additional Notes:** _____
_____

**Describe briefly your present symptoms**: _____

_____
_____
_____
_____
_____
_____

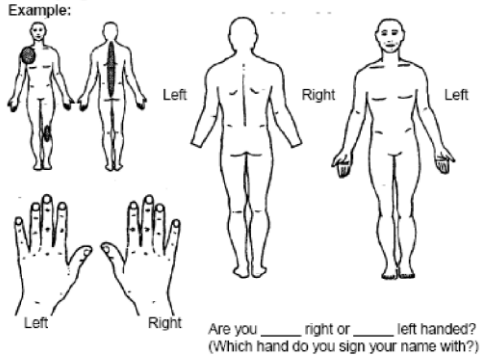
**When did your symptoms start?** _____

_____
_____
_____
_____

**What diagnosis have you been given, if any?**

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

Example:




Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

_____
_____
_____

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

Long Beach Rheumatology
206 West Park Ave
Long Beach, NY 11561
P: 516-897-3885 F: 516-897-3887

## ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION

I authorize the release of any medical information necessary to process any outstanding claims for services rendered. I permit a copy of this authorization to be used in place of the original.

I certify that the information that I have reported about my insurance is correct & active.

***I understand that I will be held responsible for any services rendered that are not paid by my insurance company which includes but not limited to outstanding Deductibles not met for the current year and/or co-insurance balances. Patient Initials*** ___

I understand that I am responsible for a **$50.00** fee for any visits not canceled 24 Hours Prior to the scheduled appointment. ***Patient Initials*** ___

Print Name _____

Sign Name _____

Date _____