LAS VEGAS RHEUMATOLOGY ASSOCIATES

Date:______________

Patient Name:

____

Last First Middle

Patient Social Security #: _________-_________-_________

Gender: ☐ Male ☐ Female Patient Date of Birth: _____/_____/_____

Patient Address: ____
Street/ P.O. Box

____
City State Zip Code

Phone# (____) ______________ Cell# (____) ______________

Email Address: ____

Patient Status (circle one): Single Married Widowed Divorced

1. **Primary Insurance:**
   Name: ______________________ Policy Holders Name: ______________
   Relationship to Patient: ________________ Date of Birth:_____/_____/_____
   SSN: _______-_______-_______ Policy#/Group#:______________________
   Insurance Contact Number: ____
   Insurance Mailing Number: ____

2. **Secondary Insurance:**
   Name: ______________________ Policy Holders Name: ______________
   Relationship to Patient: ________________ Date of Birth:_____/_____/_____
   SSN: _______-_______-_______ Policy#/Group#:______________________
   Insurance Contact Number: ____
   Insurance Mailing Number: ____

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE

1. Acknowledgement of Privacy Practice Notice

I hereby consent to the use or disclosure of my protected health information by, or on behalf of, Las Vegas Rheumatology Associates, for purposes of treatment, payment, or healthcare operations. I understand that may protected health information may be used for such purposes without my written authorization.

______________________________________ ____________________

Signature of Patient Date

2. Patient Record of Disclosure

In general, the HIPPA 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 the PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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

☐ Home#:____________________ ☐ Cell#:________________________

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of information for the PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to use or disclosures made pursuant to an authorization requested by the individual.

Healthcare entitles that we must keep records of PHI (protected health information) disclosed. Information provided below if completed properly will constitute as an adequate record or consent.

Signature of Patient/Parent/Guardian Date

Cancellation of Appointment Policy

Thank you for choosing Las Vegas Rheumatology Associates to meet with your healthcare needs. In order to serve you better we ask that if you have an appointment scheduled please give us a 24 hour notice of cancellation of the appointment.

Failure to do so will result in a $25.00 fee to your account. Payment of the fee is due the following visit. Thank you for your cooperation in understanding the terms of the practice.

Gross non compliance with the treatment plan will result in discharge of patient from the practice. Three (3) consecutive no-shows to appointment or cumulative of four (4) cancelled appointments will constitute gross non compliance with the treatment plan.

Signature of Patient Date

Payment Policy

Payment is due in full at the time of service. We bill most insurance companies as a courtesy to you, but you are ultimately responsible for all charges incurred. Deductibles, co-pay and coinsurance are due at the time of service.

Signature of Patient/Parent/Guardian Date

Insurance Waiver Statement/Disclaimer

I understand that my insurance carrier may not cover some services, or may deny some recommended and performed services. I am financially responsible for all charges whether or not paid by my insurance company. I will be responsible for payment of these charges.

Signature of Patient/Parent/Guardian Date

Print Name

Patient Emergency Contact:

Name: ______________________________ Relationship: ____________________________
Phone#: (_____)_________________

Name: ______________________________ Relationship: ____________________________
Phone#: (_____)_________________

Please List all the Health Care Providers you have seen within the last 12 month: (Please include name and Contact number):

____________________________________ ____________________________________

____________________________________ ____________________________________

Please List all additional Information that you feel like your health care provider should know about you in order to serve you better:

____
____
____
____
____
____
____
____
____

Consent to Treat:
I hereby authorize employees and agents; Including physicians assistants and nurse practitioners; and or medical assistants of this office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physician; Including consultations, associates, and assistants of the physicians'' choice.

The duration of this consent is indefinite and continues until revoked in writing. In understand that by signing this consent I have read and understand the following.

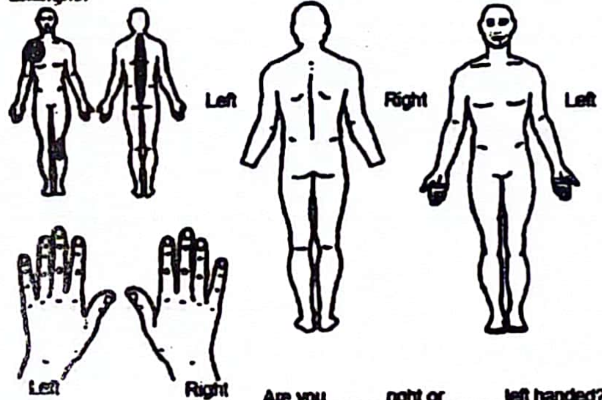
RHEUMATOLOGY PATIENT HISTORY FORM

Name of your primary care physician: ______________________

Describe briefly your present symptoms: ______________________

When did your symptoms start? ______________________

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



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

What diagnosis have you been given, if any?

____

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

____

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

____

Pharmacy: ______________________

On the lines provided below provide the names and numbers of the person(s) you wish to have access to any or all medical information you accumulate as a patient in this office. Note: You may also list any Doctors you wish to share information with.

1.____

Name	Relationship	Phone#

2.____

Name	Relationship	Phone#

3.____

Name	Relationship	Phone#

4.____

Name	Relationship	Phone#

5.____

Name	Relationship	Phone#

____ ________________

Signature of Patient Date

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

	Yourself	Relative	→	Name/relationship
Arthritis (type unknown)	❑	❑	→	______
Osteoarthritis	❑	❑	→	______
Rheumatoid arthritis	❑	❑	→	______
Gout	❑	❑	→	______
Lupus or "SLE"	❑	❑	→	______
Ankylosing spondylitis	❑	❑	→	______
Childhood arthritis	❑	❑	→	______
Sjogren's syndrome	❑	❑	→	______
Osteoporosis	❑	❑	→	______
Psoriasis/psoriatic arthritis	❑	❑	→	______

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) ______
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other significant illnesses (please list): ______

______

Previous Operations

Type	*Year*	*Reason*
1. ______	______	______
2. ______	______	______
3. ______	______	______
4. ______	______	______
5. ______	______	______
6. ______	______	______
7. ______	______	______

Any previous fractures? ❑ No ❑ Yes
Describe ______

Any other serious injuries? ❑ No ❑ Yes Describe ______

Do you smoke? ❑ Yes ❑ No ❑ In the past - How long ago? ______

Do you drink alcohol? ❑ No ❑ Yes : Usual drink: ______ How much: ______

Has anyone ever told you to cut down on your drinking? ❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ No ❑ Yes If yes, please list: ______

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? ______________________________

____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	Dose (include strength and number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

PERSONAL HISTORY

What is your highest educational level? ❑ High school ❑ Some college courses ❑ College graduate ❑ Advanced degree

What is your current or past occupation? ______________________________

Are you currently working? : ❑ Yes ❑ No If yes, hours/week ______ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability?______________________

What date did this disability begin? ____________

With whom do you currently live? ______________________________

How much exercise do you get each week? ______________ What kind of exercise? ____________

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at death	Cause
Father				
Mother				

SYSTEMS REVIEW

Date of last eye exam ________ Date of last chest x-ray ________

Date of last bone density test ____________

Result of last TB (PPD) test: ☐ Never done ☐ Negative ☐ Positive Date test performed: ___________

GENERAL
- ☐ Recent weight gain; how much____
- ☐ Recent weight loss: how much____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

MUSCLE/JOINTS/BONES
- ☐ Morning stiffness
  - Lasting how long ___ Minutes ___ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Joint swelling

List joints affected in the last 6 months

____
____
____
____

EARS
- ☐ Ringing in ears
- ☐ Loss of hearing

EYES
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye

MOUTH
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth

- ☐ Loss of taste
- ☐ Dryness
- ☐ Recent increase in tooth cavities

NOSE
- ☐ Nosebleeds
- ☐ Loss of smell

THROAT
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain in jaw while chewing

NECK
- ☐ Swollen glands
- ☐ Tender glands

HEART AND LUNGS
- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing

STOMACH AND INTESTINES
- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain relieved by food
- ☐ Vomiting of blood/"coffee grounds"
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools

KIDNEY/URINE/BLADDER
- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine

- ☐ Discharge from penis/vagina
- ☐ Frequent urination
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

BLOOD
- ☐ Anemia
- ☐ Bleeding tendency

SKIN
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive
- ☐ Skin tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Numbness or tingling in hands/feet
- ☐ Memory loss
- ☐ Muscle weakness

PSYCHIATRIC
- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

For women only:

Age when periods began: __________

Number of pregnancies: __________

Number of miscarriages: __________

Have you reached menopause?

☐ No ☐ Yes If yes, at what age: ____

Date of last Pap smear: __________

Date of last mammogram: __________

If you are still having periods:

Are they regular? ☐ Yes ☐ No

How many days apart? ________

Number of siblings: _______ **Number living** ________

Number of children _______ **Number living** ________ **List ages of each** ______________________

Health of children: ____

____