# Beverly Hills Rheumatology
# Office of Daniel J. Wallace, MD

## Patient Registration

Date: _____

| Personal Information | | | |
|---|---|---|---|
| Patient Name (Last, First, MI) | | Address | |
| Social Security # | | City, State | ZIP Code |
| Date of Birth | Sex Assigned at Birth ☐ M ☐ F | Home Phone | Work Phone |
| Marital Status ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Separated ☐ Widowed | | Cell Phone | |
| Primary Language | | Email Address | |
| **Primary Care Physician** First Name Last Name | | **Referred by** First Name Last Name | |

| Employment Information | | | |
|---|---|---|---|
| **Employment Status** ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Not Employed ☐ Retired ☐ Student | | | |
| Name of Employer/Union/Guild | | Occupation | |
| Employer Address | | Employer City, State | ZIP Code |

Beverly Hills Rheumatology
Daniel J. Wallace, MD
414 North Camden Dr Suite 1100
Beverly Hills, CA 90210

Phone: 310-360-9197
Fax: 310-360-6219
jody@danielwallacemd.com

| Additional Information | | | |
|---|---|---|---|
| Driver's License State/ID | Mother's Maiden Name | Place of Birth City & State | Pharmacy |
| Driver's License ID#/ID# | Patient's Maiden Name | Place of Birth City & State | Pharmacy Phone & Fax# |

| Emergency Contact | | | |
|---|---|---|---|
| Name | Relationship | Home Phone | Work Phone |
| Address, City | State & Zip Code | Legal Guardian ☐ Yes ☐ No | Cell Phone |

| Guarantor Information | | |
|---|---|---|
| Name of Person Who is Financially Responsible for the Patient | | Relation to the Patient |
| Employer | Social Security Number | Date of Birth |

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| Insurance Information - For Testing and Procedures<br>All Consultations are Fee For Service and Not Billed to Insurance | | | |
|---|---|---|---|
| Subscriber Name | | Subscriber DOB | Subscriber SSN |
| Primary Insurance ☐ PPO ☐ POS ☐ HMO | | Subscriber ID | Phone Number |
| Member Effective Date | Relationship to Subscriber | Group Number | Group Name |
| Primary Insurance Claim Address | | | |
| Subscriber Name | | Subscriber DOB | Subscriber SSN |
| Secondary Insurance ☐ PPO ☐ POS ☐ HMO | | Subscriber ID | Phone Number |
| Secondary Insurance Claim Address | | | |
| Member Effective Date | Relationship to Subscriber | Group Number | Group Name |

| Insurance Information (Medicare Patients Only) | | | |
|---|---|---|---|
| Subscriber ID# | Relationship to Subscriber | Part A Effective Date | Part B Effective Date |
| Have you assigned your benefits to a HMO?<br>☐ Yes ☐ No | | (If Yes) Medical Group Name | |

**Please sign so we may have your insurance authorization on file**

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Signature: _____ Date: _____

Please provide your insurance card(s) and driver's license to the receptionist along with this form.

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## Patient Medical Profile Questionnaire

Patient Name: _____ Date: _____

Active MyCSlink user: ☐ Yes ☐ No *Enrollment into MyCSlink is mandatory to communicate electronically with our office*

What is the special problem(s) or symptom(s) that brings you here for an appointment?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Number of children _____ Please list their ages: _____

Occupation: _____ Highest level of formal education: _____

**Family History**

| | Father | Mother |
|---|---|---|
| Status | ☐ Living ☐ Deceased | ☐ Living ☐ Deceased |
| Age at Death | | |
| Medical History | | |

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Do you have any family members with auto-immune diseases? If yes please list below:

Have you been diagnosed with any medical conditions? If yes please list below:

Please list any operations you have had:

| Type of operation | Year | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Please list any non-surgical hospitalizations:

| Reasons for hospitalization | Year | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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Please list all medications (prescription and nonprescription) and dosage that you take regularly: (You may update this in MyCSlink)

| Medication | Dosage | Medication | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | YES | NO |
|---|---|---|
| 1. Have you experienced dry eyes for 3 months or longer? | ☐ | ☐ |
| 2. Have you experienced dry mouth for 3 months or longer? | ☐ | ☐ |
| 3. Have you had a lot of hair fall out recently? | ☐ | ☐ |
| 4. Are you troubled by stiff or painful muscles or joints? | ☐ | ☐ |
| 5. Are your joints ever swollen? | ☐ | ☐ |
| 6. Do you often get a rash on your cheeks? | ☐ | ☐ |
| 7. Are you sensitive to sunlight? | ☐ | ☐ |

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| | YES | NO |
|---|---|---|
| 8. Do your fingers turn different colors in cold weather? (Raynaud's?) | ☐ | ☐ |
| 9. Do your nails pit? | ☐ | ☐ |
| 10. Have you ever had pleurisy? | ☐ | ☐ |
| 11. Have you ever had pericarditis? | ☐ | ☐ |
| 12. Have you ever been told that you had protein (albumin) in your urine? | ☐ | ☐ |
| 13. Have you ever had a false positive test for syphilis? | ☐ | ☐ |
| 14. Have you ever had a positive blood test for ANA (antinuclear antibody)? Or any abnormal blood test? If so, specify below: | ☐ | ☐ |

_____

_____

_____

## Constitutional

| | YES | NO |
|---|---|---|
| 15. Have you recently gained or lost weight? | ☐ | ☐ |
| 16. Do you often feel exhausted or fatigued? | ☐ | ☐ |
| 17. Do you frequently run low grade fevers? | ☐ | ☐ |

## ENT

| | YES | NO |
|---|---|---|
| 18. Do you have difficulty hearing? | ☐ | ☐ |
| 19. Do you have frequent ear infections? | ☐ | ☐ |
| 20. Do you hear a repeated humming or other noises in your ears? | ☐ | ☐ |
| 21. Have you had intermittent swelling of your salivary glands? | ☐ | ☐ |
| 22. Is it difficult or painful for you to swallow? | ☐ | ☐ |
| 23. Is your voice often hoarse? | ☐ | ☐ |
| 24. Do you have TMJ (Temporomandibular disease)? | ☐ | ☐ |

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| | YES | NO |
|---|---|---|
| **Integumentary(skin)** | | |
| 25. Do you have any skin conditions? If yes, please list: | ☐ | ☐ |
| _____ | | |
| **Respiratory** | | |
| 26. Do you wheeze or gasp to breathe? | ☐ | ☐ |
| 27. Do you have sleep apnea? | ☐ | ☐ |
| 28. Are you troubled by swollen feet or ankles? | ☐ | ☐ |
| **Musculoskeletal** | | |
| 29. Do you have osteoporosis? | ☐ | ☐ |
| 30. Have you been told by a doctor that you have Fibromyalgia? (Fibrositis or Myofascial Pain Syndrome)? | ☐ | ☐ |
| 31. Are you bothered by lower back pain? | ☐ | ☐ |
| 32. Have you been told by a doctor that you have sacroiliitis? | ☐ | ☐ |
| 33. Have you been told by a doctor you have a herniated disc? | ☐ | ☐ |
| 34. Have you been told by a doctor you have avascular necrosis? | ☐ | ☐ |
| **Cardiovascular** | | |
| 35. Have you ever been told by a doctor that you have high blood pressure? | ☐ | ☐ |
| 36. Do you ever get pains or tightness in your chest? | ☐ | ☐ |
| 37. Does every little effort leave you short of breath? | ☐ | ☐ |
| 38. Are you troubled by swollen feet or ankles? | ☐ | ☐ |
| 39. Have you ever been told that you have a heart murmur? | ☐ | ☐ |

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| | YES | NO |
|---|---|---|
| **Psychiatric** | | |
| 40. Have you ever desired or sought psychiatric help? If yes for what diagnosis? | ☐ | ☐ |
| _____ | | |
| 41. Do you ever have difficulty falling or staying asleep? | ☐ | ☐ |
| 42. Do you usually feel lonely or depressed? | ☐ | ☐ |
| 43. Do you have bipolar disorder? | ☐ | ☐ |
| 44. Do you have difficulty relaxing? | ☐ | ☐ |
| **Neurological** | | |
| 45. Do you have frequent headaches? | ☐ | ☐ |
| 46. Is any part of your body always numb? | ☐ | ☐ |
| 47. Are you troubled by dizzy spells or lightheadedness? | ☐ | ☐ |
| 48. Have you ever had a stroke? | ☐ | ☐ |
| 49. Have you ever had seizures, fits or convulsions? | ☐ | ☐ |
| **Gastronintestinal** | | |
| 50. Are you troubled by heartburn? | ☐ | ☐ |
| 51. Do you easily become nauseated (feel like vomiting)? | ☐ | ☐ |
| 52. Do you have gas/bloating? | ☐ | ☐ |
| 53. Are bowel movements often loose? | ☐ | ☐ |
| 54. Are you often constipated? | ☐ | ☐ |
| 55. Are your bowel movements ever black or bloody? | ☐ | ☐ |

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| | YES | NO |
|---|---|---|
| **Hematologic** | | |
| 56. Have you ever had idiopathic thrombocytopenia purpura (ITP)? | ☐ | ☐ |
| 57. Have you ever had a blood or bone marrow disorder?<br>If yes, please specify: | ☐ | ☐ |
| 58. Have you ever been treated for a blood clot with blood thinners? | ☐ | ☐ |
| 59. Have you been told by a doctor that you have antiphospholipid syndrome? | ☐ | ☐ |
| 60. Have you ever had cancer of any kind?<br>If yes, what kind? | ☐ | ☐ |
| When and where were you diagnosed?_____ | | |
| 61. Have you ever had a blood transfusion? | ☐ | ☐ |
| 62. Have you ever been told that you are/were anemic?<br>If yes, do you have (check all that apply): | ☐ | ☐ |
| ☐ Low iron ☐ Low B12 ☐ Heavy periods ☐ Anemia of chronic disease | | |
| ☐ Bleeding ulcers ☐ Anemia due to medication ☐ Heavy periods | | |
| 63. Have you ever had low white blood cell count? | ☐ | ☐ |
| 64. Have you ever had low platelet count? | ☐ | ☐ |
| **Allergy/Infection** | | |
| 65. Have you ever had a positive skin test or blood test for TB? | ☐ | ☐ |
| 66. Have you ever had Hepatitis?<br>If you are allergic to any medication or food, please list them below: | ☐ | ☐ |

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |

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| | YES | NO |
|---|---|---|
| **Exposure History** | | |
| 67. Have you ever smoked cigarettes regularly? (if no skip to question 69 ) | ☐ | ☐ |
| If yes, how old were you when you started smoking? _____ | | |
| How many years have you or did you smoke? _____ | | |
| How many cigarettes per day (on average)? _____ | | |
| 68. Do you smoke cigarettes now? | ☐ | ☐ |
| 69. Currently, do any members of your household smoke regularly? | ☐ | ☐ |
| If yes, specify relationship to you (example: spouse): _____ | | |
| 70. Do you drink any alcohol? (if no skip to question 73) | ☐ | ☐ |
| 71. How often do you typically have a drink containing alcohol? _____ | | |
| 72. Have you ever been told that you have a drinking problem? | ☐ | ☐ |
| 73. Have you ever used illicit injection/IV drugs (heroin, amphetamines, etc.) | ☐ | ☐ |
| 74. Are you sexually active? | ☐ | ☐ |
| **For Men only** | | |
| 75. Have you ever been told you have prostate trouble? | ☐ | ☐ |
| **For Women Only** | | |
| 76. At what age did you begin having menstrual periods? _____ | | |
| 77. Have you ever taken birth control (pills, patches, IUD's, injections, implants)? | ☐ | ☐ |
| If yes please list type(s) of birth control you have used: | | |
| _____ | | |
| _____ | | |
| _____ | | |

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| | YES | NO |
|---|---|---|
| 78. Do you have a history of irregular menstrual periods? | ☐ | ☐ |
| 79. Do you still have menstrual cycles?<br>(If no, what was your age at the time menstrual cycles stopped?) _____ | ☐ | ☐ |
| 80. Have you had a hysterectomy? | ☐ | ☐ |
| 81. Have you had a mammogram?<br>If so, what was the month/year of most recent mammogram? _____ | ☐ | ☐ |
| 82. Have you ever had lumps in your breast? | ☐ | ☐ |
| 83. Do you experience PMS (premenstrual syndrome)? | ☐ | ☐ |
| 84. What was the year of your last pap smear? _____ | | |
| 85. Have you ever experienced difficulties with infertility? | ☐ | ☐ |

86. Fill in the number of each of the following if applicable:

| | | | |
|---|---|---|---|
| Pregnancies | | Cesarean operations | |
| Children born alive | | Stillbirths | |
| Premature births | | Miscarriages | |
| Abortions | | | |

**Have you ever had any of the following conditions?**

| | | |
|---|---|---|
| 87. Ulcers | ☐ | ☐ |
| 88. Oral Ulcers | ☐ | ☐ |
| 89. Phlebitis/Blood clots | ☐ | ☐ |
| 90. Tuberculosis | ☐ | ☐ |
| 91. High cholesterol/triglycerides | ☐ | ☐ |
| 92.Psoriasis/Psoriatic Arthritis | ☐ | ☐ |
| 93. Crohn's Disease | ☐ | ☐ |
| 94. Ulcerative Colitis | ☐ | ☐ |
| 95. Gout | ☐ | ☐ |

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| | YES | NO |
|---|---|---|
| 96. Any muscle weakness and joint pain? Check mark applicable: | ☐ | ☐ |

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Knees
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders
- ☐ Ankle

| | | |
|---|---|---|
| 97. More than 15 pound weight gain or loss in the year? | ☐ | ☐ |
| 98. Do you often take antacids or laxative? | ☐ | ☐ |
| 99. Have you ever been exposed to any toxic chemicals? | ☐ | ☐ |

If yes, please list the name of the toxic chemical: _____

| | | |
|---|---|---|
| 100. Have you ever been treated for venereal disease? | ☐ | ☐ |

If so, for what diagnosis? _____ What year? _____

| | | |
|---|---|---|
| 101. Have you had physical therapy in the last year? | ☐ | ☐ |
| 102. Have you ever had plastic surgery? | ☐ | ☐ |

If so, of what nature and when: _____

103. Have you had any of the following diagnostic tests or procedures in the last year?
Please write down the month/year:

Chest X-ray _____ CAT Scan _____

Electrocardiogram (EKG) _____ X-Ray of any joints? If so, please list them: _____

TB skin test _____ _____

MRI _____ _____

Is there anything important in your medical history that we did not ask which might be useful for the doctors to know?

_____

_____

_____

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# Beverly Hills Rheumatology
# Office of Daniel J. Wallace, MD

## Consent to release medical records

Patient Name: _____ Home Number: _____

Date of birth: _____ Cell Number: _____

I hereby authorize and request that _____
*Name of facility/individual*

_____
*Address* *City/State/Zip* *Phone number/fax number*

**Release information from my records to the following:**

Name of the Facility/individual: Beverly Hills Rheumatology Office of Daniel J. Wallace, MD

414 North Camden Dr Suite 1100 (*Address*) Beverly Hills, CA 90210 (*City/State/Zip*) 310-360-9197 (*Phone number*) 310-360-6219 (*Fax number*)

**Please be specific regarding record and dates requested Information to be released:**

☐ Diagnosis and record of treatment _____

☐ Laboratory and/or X-ray reports _____

☐ Entire file (excluding confidential and psychiatric records, if any) _____

Other: _____

Be advised that if you are requesting a copy of your medical record, a copying fee shall apply.
It is prohibited by law to release/disclose the attached/enclosed information to anyone except those specified above.
I understand that this Authorization alone may not authorize release psychiatric or HIV information:

***In signing, I am aware that this authorization is valid for 1 year after today***

Patient Signature: _____ Date: _____

Disposition/date: Mailed certified/return receipt requested (date) _____

Faxed (date and time) _____ ID Verification by: _____

Records given to patient / date and time _____ Provider's approval: _____

Patient will pick up _____ Patient paid date: _____

# Beverly Hills Rheumatology
# Office of Daniel J. Wallace, MD

## Office policies/agreement

**Financial agreement** - As the responsible party, you are responsible if your insurance company declines to pay for any reason. The patient or the responsible party must:
- Inform this office of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Pay any required fees at the time of the visit, as well as all previous balances due.
- Pay any additional amount owing within 30 days of receiving a statement from our office.
- Returned Checks – If a payment is made on an account by check, and the check is returned for any reason, the responsible party will be responsible for the original check amount in addition to a $35 service charge.
- Collections – The responsible party may be sent to collections after 90 days past due, and interest will be added. If your account is sent to collections, you will be discharged from the practice. Once the balance is settled, your account will be reviewed to be reinstated as a patient.

**Late Policy –** Our office tries to allow a 15 minute grace period from the time you are requested to be in for your appointment. Past the 15 minutes, you may be given the option to wait for another appointment time on the same day if one is available, or you may be asked to reschedule your appointment. If you are seen past the 15 minute grace period you will be charged a late fee of $50.

**No Show Policy** – If you are unable to keep an appointment, our office requires at least 24 hour notice. You can cancel/reschedule an appointment by speaking to someone from the office in person or on the phone, leaving a voicemail message, or emailing a staff member who will confirm receipt of your message. New patients will be charged $150 for a no show, follow up visits will be charged $75 for a no show.

**External prescription history** – I authorize Beverly Hills Rheumatology and its Affiliated Providers to view my external prescription history via the MyChart service. I understand that this information may be needed to best assist with my care.

**Prescription policy** – I understand that my doctor will attempt to refill prescription request within 72 hours (Monday –Friday). Refill request may be done in person at my appointment, via phone or voicemail, via letter to my doctor's office, or through CS link. I understand I must allow adequate time to ask for refills before I run out of medicine, including enough lead time for us to prepare prescriptions for you to mail to a prescription service.

**Narcotics policy** - Due to increasing reports of abuse of narcotics, and the subsequent surveillance of the prescription practices of physicians by the state, this office normally will not prescribe continuous pain medication. I understand if I require strong narcotics on a continuous basis, I will be referred back to my Primary Care Physician or a Certified Pain Management Physician.

**Prior Authorizations** – I understand that some medications I may take will require a prior authorization. The authorization process can take up to 2 weeks and may be longer if the insurance denies and an appeal is needed. There is a fee of $40 per authorization. If multiple appeals are needed, charges may apply. I understand that a prescription card may be requested from me and may help with the authorization process.

**Our doctors and staff truly appreciate your compliance and understanding to these policies so that we can continue to provide excellent medical care.**

**Print** _____

**Signature** _____

**Date** _____

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## Patient Consent to notice of privacy practices

In Accordance with the Health Insurance Portability and Accountability Act (HIPAA), you have been provided with our Notice of Privacy Practices that provides information about how we may use and disclose protected health information ("PHI") about you. The notice provides a more complete description of information uses and disclosures.

As part of your healthcare, we maintain health records that describe your health history, symptoms, examinations and test results, diagnosis, treatment and plans for future care or treatment. This information serves as a basis for planning your care and treatment; a means of communication among other health professionals who contribute to your care; a source of information for applying your diagnosis and healthcare information to bill third parties; a means by which a third-party payer can verify that services billed were actually provided; and a toll for routine healthcare operations such as assessing quality and reviewing the delivery of medical services.

You have the right to review our Notice before signing this consent. As provided in our Notice, the terms of our notice and/or privacy practices may change. If we change our Notice and/or privacy practices, we will provide you with a revised copy by mailing it to your then-current address.

You have the right to object to the use of disclosure of your health information. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations in accordance with the Notice of Privacy Practices. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

**Initial {___} I request the following restrictions to the use or disclosure of my health information:**

You have the right to review our Notice before signing this consent. As provided in our Notice, the terms of our notice and/or privacy practices may change. If we change our Notice and/or privacy practices, we will provide you with a revised copy by mailing it to your then-current address.

**Signature** _____

**Date** _____

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