WELCOME TO
Great Lakes Center of Rheumatology West

The Great Lakes Center of Rheumatology West health care providers are committed to bringing you a quality of excellence in health care. Our areas of focus are arthritis, osteoporosis, musculoskeletal, autoimmune, and related diseases.

- Your visit and services will focus on evaluation of your current health problem and resolution for that problem.
- Review of labs, x-rays, and special studies that pertain to your specific problem.
- Evaluation of your current health care plan, to plan for future care, prevention of new health problems, and to guide you in becoming knowledgeable and self-empowered to direct your own health care.

Great Lakes Center of Rheumatology West
Formerly Beals Institute

JOSHUA JUNE, DO
IYAD AL-SHWAF, MD
TIMOTHY PALMER, PA-C
KOBI MOSELEY, PA-C
ALLISON TREVINO, PA-C
KIMBERLY FRAZIER, NP

Office hours by appointment only

Phone (517) 321-1525

Great Lakes Center of Rheumatology West
4333 W. St. Joe Hwy.
Lansing, Michigan 48917

Welcome to our office. Our goal is for you to receive state of the art health care. We would like to take this opportunity to explain our office policies.

- We are committed to assisting our patients in utilizing their health insurance plans but with greater than 100 plans in existence, you must be the one who is the expert on your plan.

- Great Lakes Center of Rheumatology West participates in select insurance carriers and HMO's. We recommend that you verify our participation in your plan. We will bill eligible services to your primary insurance carrier.

HMO/PPO PLANS: You must provide written authorization from your primary care physician for your visit. You will be held responsible for any unauthorized services.

- If you have an insurance other than those we participate with, we will complete claim forms for diagnostic tests and procedures. It is the patient's responsibility to collect payment from their insurance carrier.

FEES FOR OUR SERVICES

- Fee schedules are available upon request. Fees are based on the complexity of the problem, complexity of the problem solving, the number of problems, and insurance criteria. Office visits provided by Nurse Practitioners/Physician Assistants are the same fees as the physician or per Medicare and insurance regulations.

- Appointments cancelled without a notice of 1 business day will be subject to a cancellation charge of $100 for a new patient and $25 or more for a return visit.

- After your second visit or when your condition is stable, your care may be provided by a Nurse Practitioner or Physician's Assistant. All care provided is in direct coordination with the physicians.

- Nurse Practitioners and Physician's Assistants are Master's Degree educated in advanced health care. They are specifically further trained in Rheumatology by our physicians.

Your new patient appointment is scheduled for:

Date: _____

Time:_____AM/PM

With: _____

Please call (517) 321-1525 to confirm your visit at least 2 business days prior to your visit.

Thank you for selecting the Great Lakes Center of Rheumatology West for your quality medical care in arthritis and related care.

Great Lakes Center of Rheumatology West

Arthritis, Osteoporosis, and Autoimmune Diseases

Thank you for choosing the Great Lakes Center of Rheumatology West. We would like to take this opportunity to acquaint you with our practice and provide you with some useful information before your visit.

1. **Your First Visit**
   - Plan to arrive about 15 minutes early to fill out any paperwork.
   - First visits may last up to 1-2 hours so please bring a book and/or a snack.
   - Please remember that emergencies do occur and may delay your appointment.

* Please refrain from wearing any scented lotions or perfumes to your appointments or you may be rescheduled.

2. **What To Bring**
   - Please bring your driver's license, all insurance information (including the cards), recent labs and x-ray reports and a list of your current medications.
   - Please bring the enclosed new patient information filled out. It will speed up the check-in process if this information is complete.
   - If your insurance requires an authorization, it is YOUR responsibility to contact your primary care physician to have completed. Please check with your insurance to verify coverage, deductibles, and co-pays. Our staff will be happy to answer any questions regarding our physicians' participation in the various insurance plans.
   - **ALL CO-PAYS ARE DUE AND PAYABLE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, AND ALL MAJOR CREDIT CARDS.**

**** I understand that this office does not participate in Worker's compensation, No Fault Insurance, or any Auto Injury related cases and I will be responsible for payment if this visit is a result of such.**

I acknowledge that I have had the opportunity to receive a copy of this office's Notice of Privacy Practices.

_____ _____

Printed Name of Patient or Guardian Date

_____ _____

Signature of Patient or Guardian Date of Birth

There are continuously medical students, interns, resident, and fellows present in our clinic. These are doctors in training and work in the clinic under our supervision. We request your willingness to allow their participation in your care, and we assure you that they are closely monitored by us, and are capable of participating. It has been our experience that the teaching atmosphere improves the environment in our clinic, and actually improves the overall benefit to our patients.

We hope your visit with us is a pleasant one. If there is anything we can do to make your first visit more smooth, please do not hesitate to call us at 517-321-1525.

Thank you,

Great Lakes Center of Rheumatology West Scheduling Staff

Great Lakes Center of Rheumatology West

Arthritis, Osteoporosis, and Auto Immune Diseases

Patient Registration Form

Date of First Appointment:_____ Work Related? Y / N Auto Related? Y / N

Personal Information

Name:_____ Date of Birth:_____ Sex:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Primary Phone:_____ Alt. Phone:_____ Email Address:_____

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Employer:_____ Occupation:_____

Highest Level of Education Completed: ☐ High School ☐ College ☐ Graduate School

Responsible Party Information

Primary Insurance Carrier:_____ Subscriber Name:_____

Subscriber Relationship (if not self): Spouse / Parent Subscribers Date of Birth: _____

Secondary Insurance Carrier:_____ Subscriber Name:_____

Subscriber Relationship (if not self): Spouse / Parent Subscribers Date of Birth: _____

Emergency Contact Information

Name:_____ Phone #:_____ Relationship to Patient:_____

Name:_____ Phone #:_____ Relationship to Patient:_____

Referral Information

Referring Physician: _____

Primary Care Physician (if different from referring): _____

Patient Name _____ DOB _____ Date _____

Briefly describe your present symptoms: _____

_____

_____

_____

_____

_____

_____

_____

Approximate Date symptoms began: _____

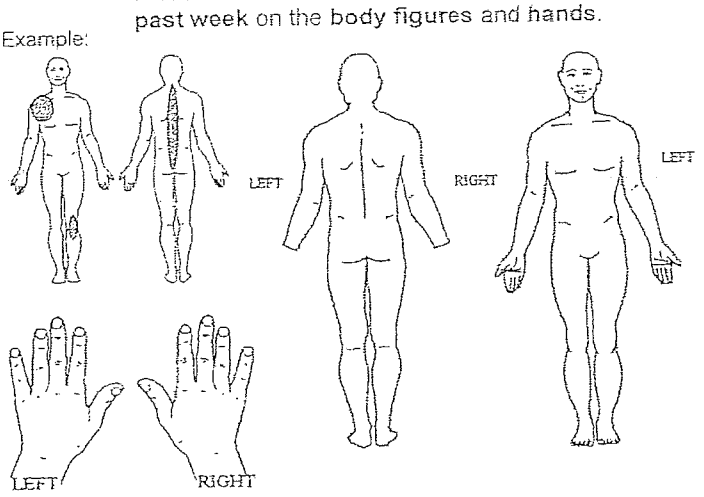
Date of last Chest X-Ray: _____

Date of last Tuberculosis Test: _____

Date of last Bone Density Test: _____

Date of last Eye Exam: _____

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



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum 1999;42 (9):1797-808. Used by permission.

Rheumatologic (Arthritis) History

*At any time have you or a blood relative had any of the following? (Check if "YES")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (Unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	
Other Arthritis conditions:					

Family History

(Please mark appropriate numbers for family members)

(1) High Blood Pressure	(2) Heart Disease	(3) Epilepsy/Seizures	(4) Diabetes	(5) Cancer	(6) Asthma
(7) Hay Fever/Allergies	(8) Arthritis	(9) Kidney Disease	(10) Glaucoma	(11) Stroke	(12) Migraine
(13) Mental Illness	(14) Alcoholism	(15) Bleeds Easily	(16) Anemia	(17) Psoriasis	(18) Eczema
(19) Osteoporosis	(20) Obesity	(21) Blindness	(22) Deaf	(23) Intellectual Disability	

Family Member	Alive	Deceased	#'s that apply	Cause of Death/Age
Father				
Mother				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Mother's Mom				
Mother's Dad				
Father's Mom				
Father's Dad				

Patient Name________________________ DOB________________ Date______________

Continuation Sheet

Date:	Wt:	Ht:	BP:	P:	R:	GSR:

Patient Name _____ DOB _____ Date _____

Social History

Do you drink caffeinated beverages? ☐ Yes ☐ No
If yes, what type? _____
How many servings per day? _____
Do you smoke? ☐ Yes ☐ No ☐ Past-How long ago?_____
If yes or past, how many packs/day? _____
Do you drink alcohol? ☐ Yes ☐ No
If yes, how many drinks per week? _____
Do you use drugs for reasons that are not medical? ☐ Yes ☐ No
If yes, please list: _____
Do you exercise regularly? ☐ Yes ☐ No
Type? _____
Amount per week? _____

Pregnancy History

Do you have children? ☐ Yes ☐ No
If so, what year(s) were they born? _____
# of Pregnancies? _____ # of Deliveries? _____
Miscarriages/Abortions: _____
# of Living Children: _____ # of Deceased Children: _____
Are you currently pregnant? ☐ Yes ☐ No
Birth Control Method: _____

Immunizations

(Write year of last injection)

Flu: _____ Pneumonia: _____
Shingles: _____ Covid 19:_____
Manufacture:_____

Past Medical History

Check the box if you currently have or ever had any of the following:

- ☐ Cancer
- ☐ Goiter
- ☐ Cataracts
- ☐ Heart Problems
- ☐ Leukemia
- ☐ Diabetes
- ☐ Stomach Ulcers
- ☐ Jaundice
- ☐ Pneumonia
- ☐ HIV/AIDS
- ☐ Glaucoma
- ☐ Nervous Breakdown
- ☐ Migraines
- ☐ Kidney Disease
- ☐ Anemia
- ☐ Emphysema
- ☐ Asthma
- ☐ Stroke
- ☐ Epilepsy
- ☐ Rheumatic Fever
- ☐ Colitis
- ☐ Psoriasis
- ☐ High Blood Pressure
- ☐ GERD
- ☐ Weakness in Arms/Legs
- ☐ Seizures
- ☐ Night Sweats
- ☐ Rheumatic Fever
- ☐ Loss of Appetite
- ☐ Change of Taste in Food
- ☐ Shingles
- ☐ Difficulty Controlling Bowels/Bladder
- ☐ Tuberculosis

☐ Other Significant Illness (please list):_____

SYSTEMS REVIEW

As you review the following list, please check any of the problems, which have significantly affected you.

General
- ☐ Fatigue
- ☐ Recent Weight Gain Amount:_____
- ☐ Recent Weight Loss Amount: _____
- ☐ Sleeping Difficulty

Skin
- ☐ Hair Loss
- ☐ Rash

Ears, Nose, Mouth, Throat
- ☐ Headache
- ☐ Visual Disturbances
- ☐ Decreased Hearing
- ☐ Ringing in Ears
- ☐ Seasonal Allergies
- ☐ Oral Ulcers

Neck
- ☐ Neck Pain
- ☐ Neck Stiffness

Respiratory
- ☐ Cough
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Hypertension
- ☐ Shortness of Breath
- ☐ Swelling of Extremities
- ☐ Cold Extremities

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Genitourinary
- ☐ Blood in Urine
- ☐ Painful Urination

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Myalgia

Neurological
- ☐ Dizziness
- ☐ Numbness
- ☐ Memory Loss

Psychiatric
- ☐ Anxiety
- ☐ Depression

Endocrine
- ☐ Appetite Changes
- ☐ Thyroid Problems

Hematology
- ☐ Easy Bruising

Patient Name _____ DOB _____ Date _____

Previous Surgeries/Testing

Type	Year	Reason

Drug Allergies:_____

_____

Food/Environmental Allergies: _____

_____

Local Pharmacy: _____

Mail-In Pharmacy: _____

Current Medications

(List **ALL** medications that you currently take, including vitamins, supplements and over-the-counter medications etc.)

Name of Medication	Dosage/mg	Frequency/How often medication is taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Patient Name _____ DOB _____ Date _____

Past Medications: Please review this list of medications below and check (√) **YES** or **NO** to whether you have ever taken each medication in the past and whether it was helpful or not. If discontinued, please write the reason why. Please only mark the medications you have tried but are **NOT CURRENTLY TAKING**.

MEDICATION	Taken		Helpful		REASON DISCONTINUED
	YES	NO	YES	NO	
NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)					
Naproxen (Aleve)					
Ibuprofen (Motrin/Advil)					
Ketoprofen					
Daypro (Oxaproxin)					
Diclofenac (Voltaren)					
Indomethacin (Indocin)					
Ketorolac (Toradol)					
Etodolac (Lodine)					
Sulindac (Clinoril)					
Meloxicam (Mobic)					
Celebrex (Celecoxib)					
Salsalate (Disalcid)					
Nabumetone (Relafen)					
Aspirin					
Arthrotec (Diclofenac/Misoprostol)					
Diflunisal					
Other:					
PAIN RELIEVERS					
Acetaminophen (Hydrocodone/Tylenol)					
Codeine (Vicodin/ Tylenol #3)					
Tramadol (Ultram/Ultracet)					
Other:					
GOUT MEDICATIONS					
Allopurinol (Zyloprim)					
Colchicine (Colcrys)					
Uloric (Febuxostat)					
Other:					
DISEASE MODIFYING ANTIRHEUMATIC DRUGS (DMARDs)					
Plaquenil (Hydroxychloroquine)					
Methotrexate					
Arava (Leflunomide)					
Imuran (Azathioprine)					
Sulfasalazine (Azulfadine)					
Quinacrine (Atabrine)					
Other:					

Patient Name _____ DOB _____ Date _____

MEDICATION	Taken		Helpful		REASON DISCONTINUED
	YES	NO	YES	NO	
BIOLOGIC DMARDs					
Actemra					
Benlysta					
Cimzia					
Enbrel					
Humira					
Ilaris					
Kevzara					
Kineret					
Orencia					
Otezla					
Remicade (Renflexis/Inflectra)					
Rinvoq					
Rituxan					
Simponi					
Simponi Aria					
Stelara					
Taltz					
Xeljanz					
Other:					
OSTEPOROSIS MEDICATIONS					
Estrogen (Premarin, etc)					
Fosamax (Alendronate)					
Evista (Raloxifene)					
Actonel (Risedronic)					
Boniva (Ibandronate)					
Forteo					
Tymlos					
Reclast (Zoledronic Acid)					
Prolia					
Other:					
MUSCLE RELAXERS					
Methocarbamol (Robaxin)					
Tizanidine (Zanaflex)					
Metaxalone (Skelaxin)					
Baclofen (Lioresal)					
Cyclobenzaprine (Flexeril)					
Carisoprodol (Soma)					
Other:					
OTHERS					
Cortisone (Prednisone)					
Hyalgan, Euflexxa, Gelsyn, Supartz, etc					

Great Lakes Center of Rheumatology West

Arthritis, Osteoporosis, and Autoimmune Diseases

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED MEDICAL INFORMATION

Patient Name (print): _____ Date of Birth _____/_____/_____

I authorize Great Lakes Center of Rheumatology West to discuss medical and/or billing information, and/or provide my personal health information to the following individuals:

Name	Relationship to Patient:	Phone:	☐ Medical ☐ Appointment ☐ Billing/Account
_____	_____	_____	
Name	Relationship to Patient:	Phone:	☐ Medical ☐ Appointment ☐ Billing/Account
_____	_____	_____	
Name	Relationship to Patient:	Phone:	☐ Medical ☐ Appointment ☐ Billing/Account
_____	_____	_____	

My preferred contact is: ☐ **Phone OR** ☐ **FMH Patient Portal**

The office:

☐ ***MAY*** **leave messages about my care on a voicemail at this number:** _____

☐ ***MAY NOT*** **leave messages about my care on a voicemail or answering machine.**

Expirations or termination of authorization – This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Right to revoke or terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Practice Manager. This can be done in-person or by mailing a request to the Great Lakes Center of Rheumatology West.

Re-disclosure – We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Great Lakes Center of Rheumatology West.

_____ _____

Patient Signature Date

4333 W. St. Joe Highway, Lansing, MI 48917-4297 PHONE (517) 321-1525 FAX (517) 321-7059