Idaho Falls Arthritis Clinic, PC

Office of

Craig D. Scoville, M.D, Ph.D.

2220 East 25th Street, Idaho Falls, ID 83404 Phone: (208) 542-9080 Fax: (208) 542-9081

Thank you for selecting our office for your Rheumatologic Care. We are looking forward to serving you. We are taking this opportunity to welcome you and to inform you of our office policies.

Office Appointments

We have scheduled you for ______________________ @ _________________________ for a new patient evaluation. Please fill out the enclosed forms consisting of the Patient Registration Sheet and the Patient Information Sheet and mail these forms back to our office. Receipt of these forms will serve as confirmation of your intention to keep your appointment. If these forms are not sent or brought in before the appointment, then the receptionist will be trying to reach you to confirm your scheduled appointment. If the forms have <u>not</u> been received by the office within 7 days of your scheduled appointment <u>and</u> the receptionist has not been able to reach you within 7 days of your appointment, then your appointment will be given to another patient. Therefore, it is crucial that you return the enclosed information or contact our office to confirm your intent to keep this appointment. We require 24 hour notice if you find it necessary to reschedule or cancel your appointment. This would allow another person the opportunity to receive the medical care that they require as well as to better utilize our busy office schedule. <u>There may be a charge if you do not appear for your scheduled visit without prior notification.</u>

Financial Policy

Copayment, coinsurance and/or deductible is required for office service at the time of the visit. If your financial situation requires a schedule of payments, please make arrangements prior to your visit. As a courtesy to you, your insurance carrier will be billed for office visits, laboratory fees and surgical procedures. If your insurance carrier(s) has not paid the balance in full within 90 days from the date of service, you will be responsible to pay the balance in full. You are legally responsible for payment in full for services provided, regardless of your insurance benefits. Following up insurances payments is your responsibility even if we have billed them and make efforts to see that they are paid.

Lab Services

Your care may require laboratory testing. A portion of this testing can be done in our office lab with the balance being done in outside laboratories. All outside lab work will be billed to you by the lab responsible for the testing. They will file your insurance claim and bill you for any balance.

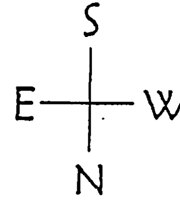
Insurance

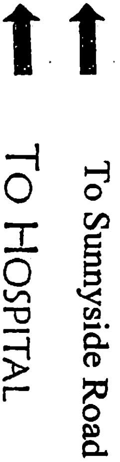
<u>We do not accept Medicaid as either a Primary or Secondary Insurance Coverage. Should you have Medicaid coverage in any form, we will not be able to render our services to you. Should you conceal your coverage from us in order to be seen, we will have to discharge you as a patient upon knowledge of this information.</u>

<u>Please provide us with complete insurance information and keep us informed of any insurance and/or address changes.</u>

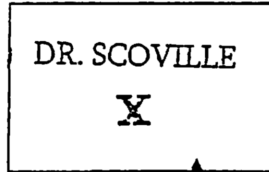
Craig D. Scoville, M.D., P.C.
(208)-542-9080

2220 East 25th Street
Idaho Falls, ID 83404

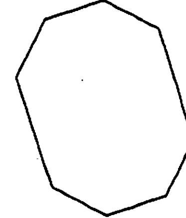




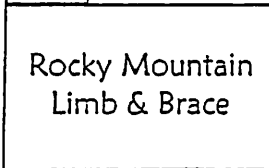
Parking B

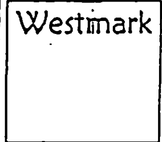


CHANNING

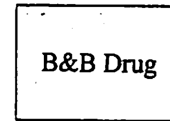


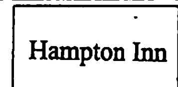
Parking A

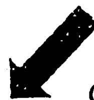




25TH STREET







Grand Teton Mall

PATIENT REGISTRATION SHEET

Idaho Falls Arthritis Clinic, PC

Office of

Craig D. Scoville, M.D., Ph.D.

Name: ____

Last First Middle

Address: ____

Home Phone: ________________ Cell: ______________ Work Phone: ____________

Birthdate: ____________ Social Security #: ____________ Spouse's Birth Date: __________

Sex: __________ Marital Status: ______ Single: _____ Married Employer: ______________

Parent/Spouse: ______________________ Social Security #: ________________

Parent/Spouse Employer: ______________________ Work Phone: ____________

Emergency Contact: ______________________ Phone: ________________

Referring Physician Name: ______________________ Family Physician: ______________

****Please Note:****

We Must Receive a <u>Copy</u> of Insurance Cards for Primary and Secondary Insurances <u>Before</u> we can schedule an appointment**

Primary Insurance Company: ____

____

Policy Holder's Name SSN # Birthdate Relationship

Secondary Insurance Company: ____

____

Policy Holder's Name SSN # Birthdate Relationship

I accept the responsibility for payment to Idaho Falls Arthritis Clinic for any portion of the account that the insurance carrier does not pay. In the event that I do not have health insurance, I agree to accept responsibility for payment of my account unless prior arrangements have been made in writing with the business manager.

I authorize Idaho Falls Arthritis Clinic to release any information regarding my medical care to the insurance carriers. I authorize any medical care facility to provide all information on my medical history to Idaho Falls Arthritis Clinic. I assign Idaho Falls Arthritis Clinic all benefits of surgical and medical care, payable under the above policy(s).

Responsible Party: ______________________________ Date: ____________

Patient Information Sheet

1. Name: ______________________ Age: ____________
2. Referred by: ______________________
3. If you wish a report from Dr. Scoville sent to any other doctors please indicate name(s) and address(s):

____

____

4. What questions/problems have brought you to see a rheumatologist? ______________________

____

____

5. CURRENT MEDICATIONS (List ALL medications and dosages, including vitamins, aspirin, etc.): ____________

____

____

____

6. ALLERGIES TO MEDICATIONS (List all negative drug reactions): ______________________

____

____

7. PAST MEDICAL HISTORY:
   a. Hospitalizations for major illness (include dates): ______________________

   ____

   ____

   b. Operations (with dates): ______________________

   ____

   ____

   c. Significant injuries/accidents (List dates, circumstances, outcomes): ______________________

   ____

   ____

   ____

   d. Please check if you have (or have had) any of the following:

______	High blood pressure	______	Tuberculosis
______	Diabetes	______	Stroke
______	Rheumatic Heart Disease	______	Heart Attack
______	Heart murmur	______	Angina
______	Asthma	______	Thyroid problems
______	Gout	______	Cancer

8. FAMILY HISTORY: Please check if a family member has (or has had) one of the following:

______	Arthritis	______	Diabetes
______	Cancer	______	Thyroid Disease
______	Gout	______	Psoriasis

   If marked, please indicate relationship: ______________________

   ____

9. HABITS: If you smoke: How many packs per day? ________ Years smoked: ________ Quit? ________
   Do you drink alcoholic beverages? ________ Occasionally? ________ Daily? ________
10. SOCIAL AND FUNCTIONAL HISTORY: List who lives with you at home (Family, pets): ____________

____

11. YOUR occupation(s): ______________________

Name: ______________________ Date: ______________

General Health	No	Yes		Gastrointestinal Health	No	Yes
Weakness				Black/tarry stools		
Dizziness				Ulcer problems		
Fainting Spells				Abdominal pain		
Change in Appetite				Blood in stools		
Fever or chills				Constipation		
Fatigue				Diarrhea		
Headache				Difficulty swallowing		
Lightheadedness				Hepatitis		
Night Sweats				Heartburn		
Difficulty Sleeping				Vomiting blood		
Weight gain				Nausea		
Weight loss				Rectal bleeding		
				Vomiting		
Head & Neck Health						
Eye Redness				**Hematology Health**		
Eye Pain				Anemia		
Loss of vision				Low white blood count		
Dry eyes				Antibody deficiency		
Mouth sores				Prone to infections		
Nasal sores				Iron Deficiency		
Dry mouth				Vitamin B12 Deficiency		
Nose or ear redness & pain				Recent transfusion		
Decreased hearing						
Frequent nosebleeds				**Genitourinary Health**		
Ringing in the ears				Blood in urine		
Sinus pain				Difficulty urinating		
Sore throat				Flank pain		
Swollen glands				Painful urination		
				Urethral discharge		
Respiratory Health				Kidney stones		
Wheezing				Impaired kidney function		
Persistent cough				Impotence		
Coughing up blood						
Pain with deep breathing				**Musculoskeletal Health**		
Shortness of breath at rest				Back Pain		
Shortness of breath with activity				Neck Pain		
				Jaw Pain		
				Carpal tunnel syndrome		
Cardiovascular Health				Joint stiffness		
Swollen legs				Leg cramps		
Chest pain at rest				Muscle achiness		
Chest pain with activity				Joint pain		
Irregular heart beat				Sciatica		
Palpitations				Swollen joints		

Skin Health	No	Yes	
Psoriasis			
Rash on face			
Rash elsewhere			
Hair loss			
Easy Bruising			
Acne			
Skin discoloration			
Itching without a rash			
Nodules under the skin			
Photosensitivity			
Skin lesions			
Sun sensitivity			
Blue or Red discoloration of fingers and/or feet with cold exposure			
Neurologic Health			
Depression			
Poor balance			
Poor coordination			
Difficulty speaking			
Difficulty walking			
Irritability			
Loss of strength			
Loss of use of limbs			
Memory problems			
Pain			
Seizures			
Tics			
Tingling and/or numbness			
Tremor			