Arthritis Center

3440 DePaul Lane Suite 113 Bridgeton, MO 63044
Phone: 314-942-6464 Fax: 314-492-4636 Email : Info@drbaak.com

Dear Patient,

Welcome. We look forward to caring for you at the Arthritis Center. Our goal is to ensure you are treated with dignity and compassion during your visit. Your mission is simply to heal. You do this by attending your scheduled appointments, taking the medications and therapies we recommend and by providing us with your medical information.

Arthritis problems can be tiring and confusing. If at any time you do not understand what you have been told, please ask questions. We want to be aware of your concerns, so we can address and resolve them together as we create the best treatment plan that allows you to regain your strength and ability to function at your peak.

Getting Ready for Your Visit:

-Allow 2-3 hours for your first appointment
-Please arrive 15 minutes before your appointments to register and bring:
-The completed patient forms attached to this letter
-A list of all medications you are currently taking (including vitamins/herbals)
-Your insurance card, photo ID, and copay

Please Contact:

Your Primary Care Physician can fax us at 314-492-4636:
- A copy of your most recent labs and office notes
- A referral if your insurance requires one to see a specialist

Our Location:

The office is located at 3440 DePaul Lane, Suite 113 Bridgeton, Missouri 63044. We are on the DePaul Hospital Campus in a free standing, two story building across from the emergency room. There is an "Arthritis Center" sign on our building. The Arthritis Center is located on the ground floor with parking directly adjacent to our entrance.

New Patient Rescheduling Policy:

The office works with you to get you in ASAP for your first appointment, we understand if you need to reschedule, however it will delay the appointment 4+ weeks for the first reschedule. Due to high volume in New Patient request, we unfortunately will not be able to reschedule a New Patient appointment for a second time without **at least 48-hour notice**. A missed appointment will result in you not being able to reschedule with our office.

Follow Up Appointments and Visits:

Please make your follow-up appointment before you leave. If you need to change your appointment or make an urgent appointment, call the office at 314-942-6464. We require a 24-hour notice for appointment changes to avoid the $50.00 No show fee.
For more information about our practice, please visit our website at www.drbaak.com.

We look forward to caring for you,
Steven Baak, MD

Rheumatologist- Medical Director

RHEUMATOLOGY PATIENT HISTORY FORM

Date: _____

Name: _____ Birthdate: _____

Address: _____

Email:_____

Cell Phone: _____Pharmacy:_____ Pharmacy Phone_____

Whom do we thank for referring you here? _____

Name of your Primary Care Physician: _____

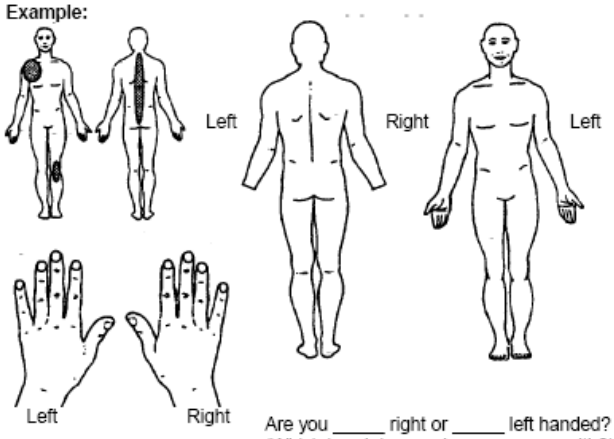
Describe briefly your present symptoms: _____

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?)

Names of other Physicians that are caring for you that we should consult: _____

Previous treatment for this problem (include physical therapy, surgery, and injections)

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

	Yourself	Relative	→	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

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				

Number of siblings: _____ Number living _____

Number of children _____ Number living _____ List ages of each _____

Health of children: _____

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
- ❑ 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? _____

Name: ***Date of Birth:*** ***Appt time:***

Email: ***Have you had your flu shot within the last year?*** ***Y or N***

1. Please check (☑) the **ONE** best answer for your abilities at this time:

OVER THE PAST WEEK, were you able to:	Without **ANY** difficulty	With **SOME** difficulty	With **MUCH** difficulty	Unable to do
Dress yourself, including tying shoe laces, doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
Turn regular faucets off and on?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of a car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
Walk two miles?	☐ 0	☐ 1	☐ 2	☐ 3
Participate in sports and games as you would like?	☐ 0	☐ 1	☐ 2	☐ 3

☐

1 = 0.3
2 = 0.7
3 = 1.0
4 = 1.3
5 = 1.7
6 = 2.0
7 = 2.3
8 = 2.7
9 = 3.0
10 = 3.3
11 = 3.7
12 = 4.0
13 = 4.3
14 = 4.7
15 = 5.0
16 = 5.3
17 = 5.7
18 = 6.0
19 = 6.3
20 = 6.7
21 = 7.0
22 = 7.3
23 = 7.7
24 = 8.0
25 = 8.3
26 = 8.7
27 = 9.0
28 = 9.3
29 = 9.7
30 = 10

2. How much pain have you had because of your condition this week? Please indicate how severe your pain has been:

No Pain ☐ Pain as bad as it can be

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

3. Considering all the ways in which illness and health conditions may affect you at this time, please indicate how well you are doing:

Very Well ☐ Very Poorly

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

4. How much trouble have you had getting a good night's sleep this past week:

No Trouble ☐ Much Trouble

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

5. Indicate the severity of your stomach problems (nausea, heartburn, pain, bloating) this week:

No Problems ☐ Severe Problems

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

6. Please indicate how severe your fatigue has been this week:

No Problems ☐ Severe Problems

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

Notice of Privacy Practices Acknowledgement

Arthritis Center will only obtain my written authorization to release information about me if it is not permitted or required by law to disclose this information without authorization.

Patient Full Name: _____ Date of Birth_____

Patient Address	City	State	Zip
E-mail address			
Home Ph:	Cell Ph:	Work Ph:	

Record of Disclosure

HIPAA privacy rules give individual the right to request restriction on disclosure of their protected health information (PHI). Individuals are also provided the right to request confidential communication of PHI be given or prohibited by alternative means such as sending correspondence, the individual's office or cell phone instead of the individual's home telephone.

Please check all methods of phone communications that you are permitting communication of PHI:

Home Phone # ___ Leave Message with Detailed Information ___Leave Message with call back number only
Cell Phone # ___ Leave Message with Detailed Information ___Leave Message with call back number only
Work Phone # ___ Leave Message with Detailed Information ___Leave Message with call back number only
Written Communication: Note address(es) that we have permission to mail Protected Health Information (PHI)

Address	City	State	Zip

I give consent to Arthritis Center to discuss or release detail of my medical care, including test results, medications, appointment and other information to persons below:

Name	Phone Number	Relationship
Name	Phone Number	Relationship

Emergency Contact – Person to call in case of emergency.

Name	**Phone Number**	**Relationship**

Authorization to Release Medical Information and Pay Benefits consent for Treatment/Privacy Notice Acknowledgement

I hereby authorize the release of any medical information necessary to bill my insurer and process claims, and I authorize payment of medical benefits be made to Arthritis Center.
I hereby consent to medical treatments rendered by Steven Baak, MD, Kristy Moore, NP, and Bryar Bequette, PA.

Signature of Patient/ Parent or Legal Guardian: _____ Date:_____

Notice of Financial Acknowledgment

Declaration made this date_____

I, Patient/Guardian, the undersigned patient/responsible party have been informed of the treatment considered necessary for _____and any extension of this treatment or procedure, whether or not currently anticipated, that the attending physician may consider necessary during the course of such in order to correct an immediate medical problem, and that such treatment and procedures (i.e. Labs, Vaccinations) will be performed by physicians who are staff members of Arthritis Center. The undersigned herby consents and grants authorization for such treatment and procedures and certifies that no guarantee or assurance has been made as to the results may be obtained. The undersigned agrees to pay for the service rendered by Arthritis Center on the release of the patient.

I do herby assign any hospital benefits of a liability of and payable by any third party for the herein-named patient to Arthritis Center unless I pay the amount in full on the release of the patient. I do authorize Health Information Services of Arthritis Center to release any information requested by my insurance company(s) or other third-party payers in connection with this assignment. I do herby appoint the Financial Manager of Arthritis Center as my lawful attorney to endorse for me any checks payable to me for debts or claims collected under this assignment and to apply any credit balance to any other debt I may owe to Arthritis Center.

Statement of Financial Responsibility

All services rendered are the payment responsibility of the patient. As a courtesy, we will bill your insurance carrier(s). The patient is responsible for all fees, regardless of insurance coverage or the usual and customary fees provided by your insurance company. It is customary to pay for the services when rendered unless other arrangements have been made in advance. If my account reaches collection status, the system will be unable to process my prescriptions and/or schedule appointments. I understand that I will be responsible for any cost incurred because of my account having to be turned over to a collection's agency or attorney. Your chart will also be assessed an additional $50.00 administrative fee to reopen your chart.

As of January1st 2017, there is a $50.00 no show policy that requires a 24-hour cancellation notice. All late fees must be paid in full before your next office visit.

Consent for Appeal:
I, with my signature, authorize (Arthritis Center), and any employee working under the direction of the physician to appeal any insurance claims/ prior authorizations that are denied on my (the patient's) behalf regarding medication, medical devices, and/or medical procedures prescribed by the physician.

I understand the full importance of this declaration.

_____ Date:_____
Patient Signature

_____ Date:_____
Witness Signature