3394 E. Jolly Rd. Ste C
Lansing, MI 48910
Phone: 517-272-9700
Fax: 517-272-9706
Website: GLCOR.com

Great Lakes Center of Rheumatology

Dr. Joshua June
Dr. Iyad Al-Shwaf
Antonio Giannelli PA-C
Kevin Duffy PA-C
Stefanie Clutten PA-C
Lauren Kaylor PA-C

Date of Appointment:_____

Arrival Time:_____ Appointment Time:_____ Provider:_____

Welcome to Great Lakes Center of Rheumatology

Our rheumatology practice aims to care for patients in a compassionate and cutting-edge style. We believe in the treatment of the entire person and our goal is to work with everyone to find the treatment plan that works for them.

This appointment was requested by another physician who is treating you and who should have already notified you of this appointment. The following points should be kept in mind to avoid delays or the need to reschedule. Visits with our physicians are by appointment only.

- **Due to the length of this packet, please arrive 20 minutes prior to your scheduled appointment time. This allows us time to process your chart. Arriving less than 20 minutes prior to your appointment will result in having to reschedule your appointment.**
- Have your attached new patient information packet COMPLETED PRIOR TO YOUR APPOINTMENT! Due to the length and detail of this paperwork, not having this completed when you arrive, will require us to reschedule your appointment.
- Bring a picture ID and all of your current insurance cards, if you do not bring your insurance cards to your new patient appointment, your appointment will be rescheduled.
- Bring copies of lab and X-ray reports with you to your appointment, if applicable.
- If your insurance changes between scheduling the appointment and your appointment date, please call our office to make sure that we accept your new insurance.
- We are frequently asked to fill out paperwork. It is office policy to meet with a patient at least 3 times before we are comfortable filling out paperwork.
- **COPAYS ARE DUE AT THE TIME OF SERVICE!** For your convenience, we accept Visa, MasterCard, and Discover. If your insurance does not cover office calls, you will be required to pay at the time of service. If you are unsure of your copay amount, please contact your insurance carrier prior to your appointment.

Contact Information

Great Lakes Center of Rheumatology

Address: 3394 E. Jolly Rd Ste C
Lansing, MI 48910

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Fax: 517-272-9706

Website: GLCOR.com

Office Hours: 7:00AM – 4:00PM Monday through Friday. Closed for lunch daily 12:00PM – 1:00PM

Directions to Great Lakes Center of Rheumatology

From Ann Arbor: Take 23 North to 96 West (exit #60B on LEFT toward BRIGHTON/LANSING) to 496 towards Lansing (exit 106B). Take the Jolly Road exit (#11). See below for instructions once you exit the freeway.

From Detroit: Take 96 West to 496 towards Lansing (exit 106B). Take the Jolly Road exit (#11). See below for instructions once you exit the freeway.

From Flint: Take 69 West to 127 South (exit #89A towards LANSING/ JACKSON). Take the Jolly Road exit (#11). See below for instructions once you exit the freeway.

From Grand Rapids: Take 96 East to 496W/ US-127 N via exit 106B toward E Lansing. Take the Jolly Road exit (#11). See below for instructions once you exit the freeway.

From Kalamazoo: Take 94 East to 69 North (exit #108 toward LANSING). Merge onto 96 East via exit #72 toward DETROIT. Then merge onto 496 W/US 127 North (exit #106B) toward E Lansing to the Jolly Road Exit (#11). See below for instructions once you exit the freeway.

From St Johns: Take 27 South to 127 South. Take Jolly Road exit (#11). See below for instructions once you exit the freeway.

*** At the end of the exit ramp there will be a stop light. Turn RIGHT at the stop light. This is Dunckel Road. Follow this road around the curve. You will see a Quality Dairy on the corner of Jolly and Dunckel. Go thru the light to the street which is Legacy. Turn left on Legacy (this is the only way you can turn). Take this all the way until it ends which will be at Pine Tree. You will be looking directly at our building. Turn right onto Pine Tree and the first driveway on the left is our driveway. We are the first office that you will see.***

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PATIENT REGISTRATION FORM

Date: _____ Work Related? Y / N Auto Related? Y / N If yes, injury date _____

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Social Security#_____

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

Primary Phone: _____ Alternate Phone: _____Email address: _____

Race:_____Ethnicity:_____Language:_____

RESPONSIBLE PARTY INFORMATION

Primary Insurance Company: _____ Subscriber Name: _____

Contract/ Policy #: _____ Group #: _____ Co-pay: _____

Subscriber relationship to patient: Self / Spouse / Parent Gender: M / F

Subscribers Date of Birth: _____

Secondary Insurance Company: _____ Subscriber Name: _____

Contract/ Policy #: _____ Group #: _____ Co-pay: _____

Subscriber relationship to patient: Self / Spouse / Parent Gender: M / F

Subscriber Date of Birth: _____

*** For Third Insurances- Please write in policy/ Subscriber information in the back of this form***

EMERGENCY CONTACT INFORMATION

Name: _____Phone: _____Relationship to Patient: _____

REFERRAL INFORMATION

Referring Physician: _____ Phone: _____

Primary Care Physician (if different from referring): _____ Phone: _____

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PATIENT INFORMATION RELEASE

Patient Name: _____ DOB: _____

I hereby give permission to release medical information regarding myself to the family and friends listed below:

_____
_____
_____

Signature of Patient: _____ Date: _____

The following information will assist us in your care, and in any communications with you, while protecting your confidentiality. Please circle "YES" or "NO" and fill in the necessary information.

I give permission to:

YES NO N/A Leave a message with test results on voicemail at my Primary Phone #.

YES NO N/A Leave a message at my Primary Phone # requesting I call the office back.

YES NO N/A Leave a message at my Alternative Phone # requesting I call the office back.

YES NO N/A Fax lab results, x-ray results, or any other information regarding my condition, to my primary care physician, or the physician that Great Lakes Center of Rheumatology is referring me to.

YES NO Fax or telephone information to and from my insurance company. This may be required, in some cases, to get the claim paid or obtain a prior authorization for medication.

YES NO Send me a notice of a potential Research Study that I may qualify for.

Signature of Patient: _____ Date: _____

CONSENT FOR TREATMENT:

I voluntarily consent to treatment by the medical staff of Great Lakes Center of Rheumatology as deemed necessary in their judgment. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of examinations, treatments or tests.

Patient or Responsible Party Signature: _____ Date: _____

HIPPA PRIVACY PRACTICES:
I agree to Great Lakes Center of Rheumatology's HIPPA and Privacy Practices. If you would like a copy of all policies, please request one at the front desk

Patient or Responsible Party Signature: _____ Date: _____

RELEASE OF INFORMATION:
I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to Great Lakes Center of Rheumatology. I am aware that my provider may release my medical information to other providers, in order to continue my care.

Patient or Responsible Party Signature: _____ Date: _____

PAYMENT POLICY:
Medicare Patients: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patient will be billed the balance.

HMO, PPO, or other Managed Care Patients: You will be responsible for paying your annual deductible and co-payments, as well as any changes for non-covered services. All copayments are due at the time of service.

Commercial Insurance Patients: If you are covered but a private or commercial plan in which our physicians are not providers, we will bill your insurance company as a courtesy, however, if your plan does not pay, you will be responsible for the entire charge. If your insurance plan does not cover office calls, you will be responsible to pay the entire amount at the time of service.

Patient co-pays are due at the time of check-in. If you do not pay your co-pay at check in you will receive a paper statement in the mail, that amount is due when received. If your payment is not received within 30 days, you will incur a $20 late fee. If your payment is not received within 60 days, you will incur a second $20 late fee. After 90 days of no payment you will be sent to collections and unable to be seen or scheduled with the practice. At any time, you may set up a payment plan with the office. There will be a $5 fee for any phoned in prescription refills. It is patient responsibility to take care of all refills during appointment. Patients may schedule an appointment to receive their refills. All cancellations require 24-hour notice, the fee for not cancelling is $25.

Patient or Responsible Party Signature: _____ Date: _____

MEDICARE PATIENTS ONLY:
This office is required to keep your signature on file authorizing us to file claims to Medicare for you and that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or a related Medicare 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 the party who accepts assignments or to me. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card: _____ Date: _____

If you have a supplement policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file.
I request authorized MEDIGAP benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on MEDIGAP card: _____ Date: _____

AMERICAN COLLEGE OF RHEUMATOLOGY
EDUCATION • TREATMENT • RESEARCH

Patient History Form

Date of first appointment: _____/_____/_____ Time of appointment: _____ Birthplace: _____
MONTH DAY YEAR

Name: _____ Birthdate: _____/_____/_____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: _____ Age _____ Sex: ❑ F ❑ M
STREET APT#

_____ Telephone: Home: (____) _____
CITY STATE ZIP Work: (____) _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses: _____

EDUCATION *(circle highest level attended):*

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/Average per work: _____

Referred here by: *(check one)* ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Describe briefly your present symptoms: _____

_____

_____

_____

_____

Date symptoms began *(approximate)*: _____

Diagnosis: _____

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

_____

_____

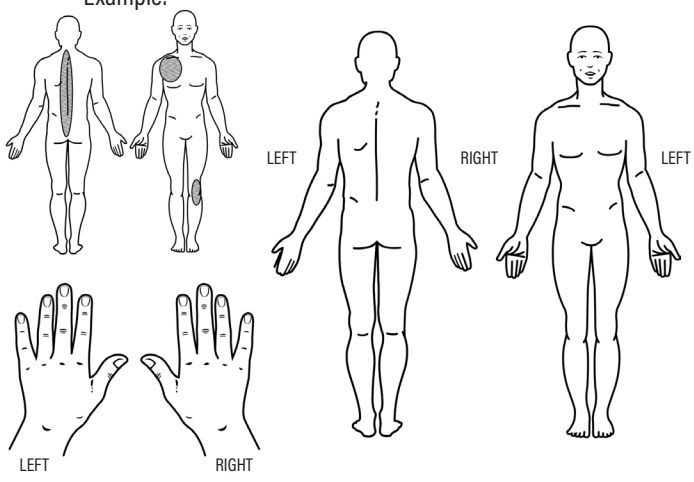
_____

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

_____

_____

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: _____

Patient's Name: _____ Date: _____ Physician Initials: _____

SYSTEMS REVIEW

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

Date of last mammogram: _____/_____/_____ Date of last eye exam: _____/_____/_____ Date of last chest x-ray: _____/_____/_____

Date of last Tuberculosis Test _____/_____/_____ Date of last bone densitometry _____/_____/_____

Constitutional

- ❑ Recent weight gain amount _____
- ❑ Recent weight loss amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears-Nose-Mouth-Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty swallowing

Cardiovascular

- ❑ Chest Pain
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, “smoky” urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began: _____

Periods regular? ❑ Yes ❑ No

How many days apart? _____

Date of last period? _____/_____/_____

Date of last pap? _____/_____/_____

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ❑ Morning stiffness

  Lasting how long?

  _____Minutes _____Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

  List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient’s Name: _____ Date: _____ Physician Initials: _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago? _____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

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 _____

How many hours of sleep do you get at night? _____

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

Do you wake up feeling rested? ❑ Yes ❑ No

PAST MEDICAL HISTORY

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

❑ Cancer	❑ Heart problems	❑ Asthma
❑ Goiter	❑ Leukemia	❑ Stroke
❑ Cataracts	❑ Diabetes	❑ Epilepsy
❑ Nervous breakdown	❑ Stomach ulcers	❑ Rheumatic fever
❑ Bad headaches	❑ Jaundice	❑ Colitis
❑ Kidney disease	❑ Pneumonia	❑ Psoriasis
❑ Anemia	❑ HIV/AIDS	❑ High Blood Pressure
❑ Emphysema	❑ Glaucoma	❑ Tuberculosis

Other significant illness *(please list)* _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

PREVIOUS SURGERIES

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

Any previous fractures? ❑ No ❑ Yes *Describe:* _____

Any other serious injuries? ❑ No ❑ Yes *Describe:* _____

FAMILY HISTORY

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

Number of siblings _____ Number living _____ Number decreased _____

Number of Children _____ Number living _____ Number decreased _____ List ages of each _____

Health of children _____

_____

Do you know any blood relative who has or had: *(check and give relationship)*

❑ Cancer _____	❑ Heart disease _____	❑ Rheumatic fever _____	❑ Tuberculosis _____
❑ Leukemia _____	❑ High blood pressure _____	❑ Epilepsy _____	❑ Diabetes _____
❑ Stroke _____	❑ Bleeding tendency _____	❑ Asthma _____	❑ Goiter _____
❑ Colitis _____	❑ Alcoholism _____	❑ Psoriasis _____	

Patient's Name: _____ Date: _____ Physician Initials: _____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes If yes, please list: _____

_____

Type of reaction: _____

PRESENT MEDICATIONS *(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)*

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: *Helped?*		
			A Lot	Some	Not At All
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

PAST MEDICATIONS: Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. *Record your comments in the spaces provided.*

Drug names/Dose	Length of time	Please check: *Helped?*			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past Flurbiprofen Diclofenac + misoprostil Aspirin (including coated aspirin) Celecoxib Sulindac Oxaprozin Salsalate Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Choline magnesium trisalcylate Diclofenac					
Pain Relievers					
Acetaminophen		❑	❑	❑	
Codeine		❑	❑	❑	
Propoxyphene		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab		❑	❑	❑	
Golimumab		❑	❑	❑	
Hydroxychloroquine		❑	❑	❑	
Penicillamine		❑	❑	❑	
Methotrexate		❑	❑	❑	
Azathioprine		❑	❑	❑	
Sulfasalazine		❑	❑	❑	
Quinacrine		❑	❑	❑	
Cyclophosphamide		❑	❑	❑	
Cyclosporine A		❑	❑	❑	
Etanercept		❑	❑	❑	
Infliximab		❑	❑	❑	
Tocilizumab		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient's Name: _____ Date: _____ Physician Initials: _____

PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: *Helped?*			Reactions
		A Lot	Some	Not At All	
Osteoporosis Medications					
Estrogen		❑	❑	❑	
Alendronate		❑	❑	❑	
Etidronate		❑	❑	❑	
Raloxifene		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal		❑	❑	❑	
Risedronate		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen		❑	❑	❑	
Tiludronate		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyaluronan		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	

Please list supplements:

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list:

Patient's Name: _____ Date: _____ Physician Initials: _____

ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No *If yes, how many?*

How many people in household? _____ Relationship and age of each _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from chair?	❑	❑	❑
Touching your feet while seated?	❑	❑	❑
Reaching behind your back?	❑	❑	❑
Reaching behind your head?	❑	❑	❑
Dressing yourself?	❑	❑	❑
Going to sleep?	❑	❑	❑
Staying asleep due to pain?	❑	❑	❑
Obtaining restful sleep?	❑	❑	❑
Bathing?	❑	❑	❑
Eating?	❑	❑	❑
Working?	❑	❑	❑
Getting along with family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness	❑	❑	❑
Do you use a cane, crutches, walker or wheelchair? *(circle one)*	❑	❑	❑

What is the hardest thing for you to do? _____

Are you receiving disability? Yes ❑ No ❑

Are you applying for disability? Yes ❑ No ❑

Do you have a medically related lawsuit pending? Yes ❑ No ❑

Patient's Name: _____ Date: _____ Physician Initials: _____

