4052 Legacy Parkway
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Lansing, MI 48911
Phone: 517-272-9700
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Great Lakes Center of Rheumatology

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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 style treatment 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.

If you must **CANCEL/ RESCHEDULE** an appointment, **we require a minimum of 24 HOURS** notice for all NEW PATIENT APPOINTMENTS. Failure to cancel your scheduled appointment will result in a **$50 charge.**

- **Due to the length of this packet, please arrive 20 MINUTES prior to your appointment time with this packet completed in FULL. This allows us time to process your chart. Arriving less than 20 MINUTES prior to your appointment or not having this packet completed will result in having to reschedule your appointment.**
- Bring your 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 our 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 Cash, Check, Visa, MasterCard, and Discover. If your insurance does not cover office visits, you will be required to pay at the time of service. If you are unsure of your co-pay amount for a specialist, please contact your insurance carrier prior to your appointment.

Your New Patient Appointment is scheduled for:

Date:_____ Arrival Time: _____

Appointment Time: _____ Provider: _____

Great Lakes Center of Rheumatology
Patient Information Release

Patient Name:_____ DOB: _____

I hereby give permission to release any medical information regarding myself to the family, friends and/or physicians listed below:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Patient Signature: _____ Date: _____

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

I give Great Lakes Center of Rheumatology permission to:

YES NO N/A | Leave a voicemail on my Primary Number.
YES NO N/A | Leave a voicemail on my Alternative Number.
YES NO | Send me a notice of potential Research Study that I may,qualify for.
Please Note: This would result into a transfer of care if you qualify for any Research Studies.

Patient Signature: _____ 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/ Responsible Party Signature: _____ Date: _____

Great Lakes Center of Rheumatology

Privacy Practice Part 1

HIPAA Privacy Practice:

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

Patient 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 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/supplement carriers. However in the event of 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 of non-covered services. All co-payments are due at the time of service.

Commercial Insurance Patients: If you are covered by 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 visits, you will be responsible to pay the entire amount of 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. At any time, you may set up a payment plan with the office. **It is the patient's responsibility to take care of all refills during the appointment.** Patients may schedule an appointment to receive their refills. All cancellations require **24 hour notice**; the fee for not canceling is $25.

Patient Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Great Lakes Center of Rheumatology

Privacy Practice Part 2

Medicare Patients Only:

The 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 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 the authorization to be used in place of the original and request payment of medical insurance benefits either to the party who except assignments or to me. Regulations pertaining to Medicare assignment of benefits apply.

Patient Signature: _____ Date: _____ ☐ Not Applicable

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 authorize 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.

Patient Signature: _____ Date: _____ ☐ Not Applicable

Patient Name: _____ Date of Birth: _____

**** If you do not have Medicare, Please check "Not Applicable", Print and Sign your name, and complete DOB and Date ****

Great Lakes Center of Rheumatology
Patient Registration Form

Work Related? Yes / No Auto Related? Yes / No Date: _____

Personal Information:

Name: _____ Date of Birth:_____ Sex:_____

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

Primary Number:_____ Alternative Phone: _____

Email Address: _____

Race:_____ Ethnicity: _____ Language: _____

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

Responsible Party Information:

Primary Insurance Company: _____ Policy Number:_____

Group Number:_____ Specialist Co-Pay:_____

Subscriber Name: _____ Subscriber DOB: _____ Gender: _____

Subscribers Relationship (if not self): _____

Secondary Insurance Company: _____ Policy Number:_____

Group Number:_____ Specialist Co-Pay:_____

Subscriber Name:_____ Subscriber DOB: _____ Gender: _____

Subscribers Relationship (if not self) :_____

Emergency Contact Information:

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Referral Information:

Referring Physician: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Great Lakes Center of Rheumatology

Directions to Great Lakes Center of Rheumatology

Address: 4052 Legacy Parkway Ste 200 (Upper level), Lansing MI 48911

Phone: 517-272-9700 **Fax:** 517-272-9706

Ann Arbor, MI:

Take **23 North to 96 West** to **Exit 60B**, on the **Left** towards **Brighton/ Lansing** to **496** towards **Lansing**, take **Exit 106B**. Take **Exit 11** to **Jolly Road.**

** see below for further instructions **

Detroit, MI:

Take **96 West** to **496 towards Lansing,** Take exit **106B**. Take **Exit 11** to **Jolly Road.** ** ** see below for further instructions **

Flint, MI:

Take **69 West to 127 South**, Take **Exit 89A** towards **Lansing/ Jackson**. Take **Exit 11** to **Jolly Road.**

** see below for further instructions **

Grand Rapids, MI:

Take **96 East** to **496W/ US-127 North**, Take **Exit 106B** toward **East Lansing**.

Take **Exit 11** to **Jolly Road.**

** see below for further instructions **

Kalamazoo, MI:

Take **94 East** to **69 North**, Take **Exit 108 towards Lansing**. **Merge** onto **96 East**, Take **Exit 72 towards Detroit**. Merge onto **496 W/US 127 North**, Take **Exit 106B** towards **East Lansing** to **Exit #11** to **Jolly Road**

** see below for further instructions **

St. Johns, MI:

Take **27 South** to **127 South**. Take **Exit 11** to **Jolly Road.**

** see below for further instructions **

*** At the end of the exit ramp there will be a stop light. Turn **Right** at the stop light. You will be on **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). We are the **second to last building on the Left** (brick building).

If you hit pine tree you went too far. ***

Great Lakes Center of Rheumatology

Arthritis, Osteoporosis, and Autoimmune Diseases

Health Assessment Questionnaire (HAQ-DI)

Today's date: _____

Patient name: _____ Date of birth: _____

Check the option which best describes your abilities **OVER THE PAST WEEK.**

In the **PAST WEEK, are you able to:**

	Without difficulty (0)	With some difficulty (1)	With much difficulty (2)	Unable to do (3)
Stand up from a straight chair?	☐	☐	☐	☐
Walk outdoors on flat ground?	☐	☐	☐	☐
Get on and off the toilet?	☐	☐	☐	☐
Reach and get down a 5 pound object like a bag of flour/ sugar just above your head?	☐	☐	☐	☐
Open car doors?	☐	☐	☐	☐
Do outside work, such as yard work?	☐	☐	☐	☐
Wait in a line for 15 minutes?	☐	☐	☐	☐
Lift heavy objects?	☐	☐	☐	☐
Move heavy objects?	☐	☐	☐	☐
Go up two or more flights of stairs?	☐	☐	☐	☐

AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

Patient History Form

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

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

Address: _____ (STREET / APT#) Age _____ Sex: ☐ F ☐ M

_____ (CITY / STATE / ZIP) Telephone: Home: (____) _____
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):*

_____

_____

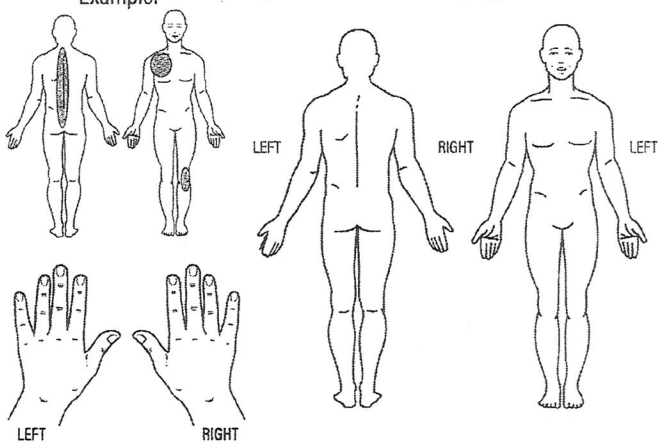
_____

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 Name: _____ Date of Birth: _____

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 Name: _____ Date of Birth: _____

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 deceased _____

Number of children _____ Number living _____ Number deceased _____ 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 Name: _____ Date of Birth: _____

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 Name: _____ Date of Birth: _____

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: