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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. **WE DO NOT PARTICIPATE WITH UNITED HEALTHCARE.**
- 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. _____
2. _____
3. _____
4. _____
5. _____
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. 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 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 Suite (200 Upper level/ 100 lower level), Lansing MI 48911

Phone: 517-272-9700 Fax: 517-272-9706 or 517-853-8238

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. *******

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.

Example:

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
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood Arthritis	<input type="checkbox"/>	Osteoporosis

Other arthritis conditions: _____

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

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")

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Goiter	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Nervous breakdown	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Bad headaches	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Colitis
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> 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)

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Heart disease _____	<input type="checkbox"/> Rheumatic fever _____	<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Leukemia _____	<input type="checkbox"/> High blood pressure _____	<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Bleeding tendency _____	<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Goiter _____
<input type="checkbox"/> Colitis _____	<input type="checkbox"/> Alcoholism _____	<input type="checkbox"/> Psoriasis _____	

4 | 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.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Circle any you have taken in the past</i>					
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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disease Modifying Antirheumatic Drugs (DMARDs)					
Certolizumab		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Golimumab		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quinacrine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tocilizumab		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PAST MEDICATIONS *Continued*

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

Please list supplements:

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

If yes, list:
