RHEUMATOLOGY CONSULTANTS of WNY

3615 Seneca Street
West Seneca, New York 14224
Telephone: 716-675-7376 Fax: 716-675-2191

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****Please fill out this packet prior to your appointment and bring it with you on the day of your visit.*

Date:_____

Dear:_____

Welcome to Rheumatology Consultants on WNY, PC

Your appointment is scheduled for:_____

Please arrive at _____AM/PM
If you do not arrive at the above stated time, you may be asked to reschedule.

Your appointment is scheduled for _____AM/PM

With_____

Your doctor will review your case and discuss planned diagnostic tests and treatment recommendations with you. You may expect your visit to last about an hour.

We look forward to meeting you at your upcoming appointment. Please feel free to call our office prior to your appointment if you have any questions or concerns. If you need to cancel or reschedule your appointment, please give us the courtesy of calling as soon as possible so we may offer your appointment time to another patient. **THERE IS A $50 FEE FOR MISSED OR CANCELLED APPOINTMENTS WITHOUT 24 HOURS NOTICE.**

In order to provide the best care and to expedite the appointment we ask that you:

- Complete the enclosed forms and bring them with you on the day of the appointment,
- Bring your photo ID, insurance cards and any prescription cards you may have with you.
- Wear or bring a pair of shorts or a comfortable t-shirt to be examined in (a paper gown will be provided if you prefer)

PARK IN THE REAR OF THE BUILDING AND USE THE BACK DOOR ENTRANCE

RHEUMATOLOGY CONSULTANTS of WNY

PLEASE PRINT

Patient Name:_____ DOB:____/____/____

Street Address:_____ APT#_____

City:_____ State_____ ZIP_____

Home Phone: ( )_____ Cell: ( )_____ Work: ( )_____

Preferred number to contact you:____Home ____Cell ____Work

SS#:_____ Email:_____

Employer:_____

INSURANCE INFORMATION

Primary Insurance Company:_____

Subscriber Name:_____ Subscriber DOB:_____

Relationship to patient:_____ Subscriber SS#_____

Insurance ID#:_____ Group #:_____

Secondary Insurance:_____

Secondary Insurance ID#:_____ Group #:_____

Subscriber Name:_____ Subscriber DOB:_____

Family MD:_____ ***Address:***_____

Referring MD:_____ ***Address:***_____

PHARMACY

Pharmacy Name:_____ *Address:*_____

City:_____ State:_____ Pharmacy Phone#:_____

**FEDERAL REGULATIONS IN REGARD TO HEALTH INSURANCE REQUIRE THE FOLLOWING INFORMATION BE INCLUDED IN YOUR HEALTH RECORDS*

PRIMARY LANGUAGE

____ENGLIGH

____SPANISH

____OTHER_____

RACE:

____CAUCASION

____AFRICAN AMERICAN

____HISPANIC

____OTHER_____

ETHNICITY:

____HISPANIC OR LATINO

____NONHISPANIC OR LATINO

Print Full Name:_____ DOB_____

Patient Signature:_____ Date:_____

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Payment of Insurance Benefits

I request that the payment of authorized Insurance benefits be made on my behalf to Rheumatology Consultants of WNY, P.C., for service rendered. I authorize Rheumatology Consultants of WNY, P.C. to release to the Healthcare Financing Administration and its agents, any medical information needed to determine benefits or benefits payable for relatable services.

Assignment of Insurance Benefits

I hereby authorize direct payment of medical benefits to Rheumatology Consultants of WNY, P.C., for Services rendered. I understand that I am financially responsible for any balance not covered by my insurance. In addition:

- Co-payments
- Personal balances are due within 30 days of billing
- I am responsible for knowing whether my insurance is active or not.
- I am responsible for knowing if the visit and procedures are covered by my insurance.
- I am responsible for any charges and services that are not covered by my insurance.

Authorization for Release of Information

I consent to the use or disclosure of my protected health information by Rheumatology Consultants of WNY, P.C., for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct the healthcare operations of Rheumatology Consultants of WNY, P.C. I understand that diagnosis of treatment of me by Rheumatology Consultants of WNY, P.C., may be conditioned upon my consent as evidenced by my signature on this document. In addition, I give Rheumatology Consultants of WNY, P.C. consent to import and review prescribed medications.

Administration Fees

- Cancellation or no show with less than 24 hours notice is a $50.00 fee
- Returned check fee is $25.00
- Charge for copying of medical records is $0.75 per page
- The office reserves the right to charge a fee for administration forms (i.e., FMLA, Disability forms etc.). Fee to be paid in advance of service.

Privacy Notice Available Upon Request

HIPAA policies are practiced at Rheumatology Consultants of WNY, P.C.

By signing I acknowledge the above information:

Print Full Name:_____ DOB_____

Patient Signature:_____ Date:_____

AMERICAN COLLEGE OF RHEUMATOLOGY

EDUCATION • TREATMENT • RESEARCH

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 week _____

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: _____

Do you have an orthopedic surgeon? ❑ Yes ❑ No If yes, Name: _____

Describe briefly your present symptoms: _____

_____

_____

_____

Date symptoms began (approximate): _____ **Example**

Diagnosis: _____

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

_____

_____

_____

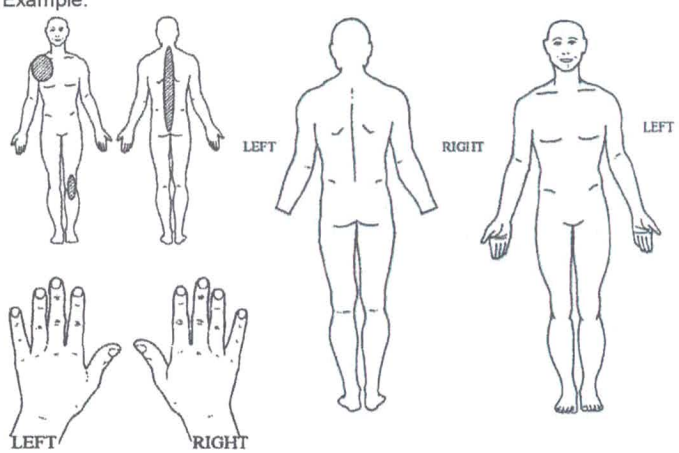
Please list the names of other practitioners you have seen for this problem:

_____

_____

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
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

Patient's Name _____ Date _____ Physician Initials _____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

_____

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/Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)		❑	❑	❑	
Codeine (Vicodin, Tylenol 3)		❑	❑	❑	
Propoxyphene (Darvon/Darvocet)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		❑	❑	❑	
Gold shots (Myochrysine or Solganol)		❑	❑	❑	
Hydroxychloroquine (Plaquenil)		❑	❑	❑	
Penicillamine (Cuprimine or Depen)		❑	❑	❑	
Methotrexate (Rheumatrex)		❑	❑	❑	
Azathioprine (Imuran)		❑	❑	❑	
Sulfasalazine (Azulfidine)		❑	❑	❑	
Quinacrine (Atabrine)		❑	❑	❑	
Cyclophosphamide (Cytoxan)		❑	❑	❑	
Cyclosporine A (Sandimmune or Neoral)		❑	❑	❑	
Etanercept (Enbrel)		❑	❑	❑	
Infliximab (Remicade)		❑	❑	❑	
Prosorba Column		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient's Name _____ Date _____ Physician Initials _____

PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		❑	❑	❑	
Alendronate (Fosamax)		❑	❑	❑	
Etidronate (Didronel)		❑	❑	❑	
Raloxifene (Evista)		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal (Miacalcin, Calcimar)		❑	❑	❑	
Risedronate (Actonel)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid (Benemid)		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol (Zyloprim/Lopurin)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen (Nolvadex)		❑	❑	❑	
Tiludronate (Skelid)		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyalgan/Synvisc injections		❑	❑	❑	
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 _____

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 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 Operations

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 of 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 _____

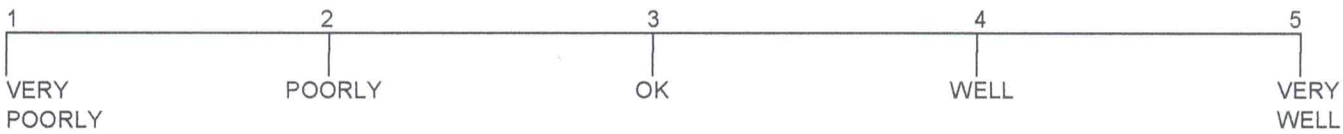
ACTIVITIES OF DAILY LIVING

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…*



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, as walker or a 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 _____