Coastal Arthritis and Rheumatism Associates

PATIENT REGISTRATION

Date:_____
Chart#:_____
Acct#:_____

Patient's Full Name: _____
Last First Middle

Home Phone: _____ Sex: □M □F Date of Birth:____/____/_____

Work Phone: _____ Who is responsible for the bill? _____

Home Address: _____
Street City State

SS# _____ Marital Status: □Single □Married □Divorced □Widowed

PATIENT INSURANCE INFORMATION

Primary Insurance Name: _____
ID# _____ Group# _____
Insured's Name: _____ DOB:_____SS#_____
Relationship to Insured: _____

Secondary Insurance Name:_____
ID# _____ Group# _____
Insured's Name: _____ DOB:_____SS#_____
Relationship to Insured: _____

Do you have a third Insurance carrier:_____
ID# _____ Group# _____
Insured's Name: _____ DOB:_____SS#_____
Relationship to Insured: _____

PLEASE PRESENT YOUR INSURANCE CARDS TO THE WINDOW

Who referred you to us? □Friend □Phone Book □Ad Doctor:_____ Other:_____

Patient Employer: _____
Address: _____

Spouse's Name: _____
Spouse's Employer: _____ Covered by their Insurance: □ Y □ N
Person to notify in case of an emergency: _____
Address:_____
Phone: _____
Relationship to the Insured:_____
How do you plan to pay for today's visit? □ Check □ Cash □ Other

Please Sign Both Places Below
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned physician of Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charges for those services.

_____
SIGNED (INSURED PERSON)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers, or others involved in the processing and collection of this claim.

_____
SIGNED (INSURED PERSON)

PROTECTED HEALTH INFORMATION

Coastal Arthritis and Rheumatism Associates, PA

Name:_____ Age:_____ Sex:_____

Birthdate: ___/___/___ Birthplace: _____
Referred here by: □ Self □ Family □ Doctor □ Other
Name of person making referral: _____
Name of your primary care physician: _____
Briefly describe your present symptoms: _____
_____
Approximate date symptoms began: _____
Diagnosis given (please list): _____
_____
Previous treatment for this problem: _____
_____
Please list the names of other practitioners you have seen for this problem:
_____

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

Yourself	relative/name	Yourself	relative/name
□Childhood arthritis	_____	□Lupus or "SLE"	_____
□Osteoarthritis	_____	□Ankylosing spondylitis	_____
□Rheumatoid Arthritis	_____	□Osteoporosis	_____
□Gout	_____	□Chronic back pain	_____

Past Medical History:

Do you 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	

Other Significant Illness (please list): _____

Previous Operations:

Type:	Year:	Type:	Year:
1)_____	_____	2)_____	_____
3)_____	_____	4)_____	_____

Any serious injuries? _____ If yes, describe: _____
_____
Menstrual:
Date when periods began: _____ Are they regular? _____ Date of last period: _____
Number of pregnancies:_____ Number of live births: _____

Habits:
Do you smoke tobacco products? _____How many packs per day? _____
Has anyone told you to cut back on your drinking? _____Drinks per day: _____
Do you or have you used recreational drugs? _____
Have you had any blood transfusions? _____

Medications:
Drug allergies? _____ To what? _____
Type of reaction: _____

Present Medications:
(list all medications you are taking at this time. Include items such as aspirin, vitamins, laxatives, calcium supplements, etc.)

Name of drug	Dose (include strength and # of pills/day)	How long have you taken this medication?	Has this helped a lot?	Has this helped some?	Has this not helped at all?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Past Medications:

Past: Please review this list of "Arthritis" medications

	Length of time taken	Good results	OK results	No results	Reactions
Tylenol with codeine					
Darvon/Darvocet					
Percocet					
Vicodin					
Methadone					
Duragesic					
Clinoril					
Feldene					
Indocin					
Meclomen					
Motrin					
Voltaren					
Daypro					
Relafen					
Lodine					
Naprosyn/Naprelan					
Celebrex					
Cortisone/Prednisone					
Medrol					
Colchicine					
Zyloprim/Allopurinol					
Gold (shots/pills)					
Plaquenil					
Penicillamine					
Methotrexate					
Imuran					
Cytoxan					
Cyclosporin					
Sulfasalazine					
Cellcept					
Remicade					
Humira					
Enbrel					
Kineret					
Orencia					
Rituxan					
Arava					
Morphine					

Family History:

Father: Age (if living) _____Health:_____Age at death:_____Cause:_____
Mother: Age (if living)_____Health:_____Age at death:_____Cause:_____
Number of your children:____ Number living:_____Number deceased:____Abortions: ___
Serious illnesses of children:_____

Do you know of any blood relatives who have or have had: (Check if yes)

□ Cancer	□ Heart Disease	□ Rheumatic Fever	□ Tuberculosis
□ Leukemia	□ High Blood Pressure	□ Epilepsy	□ Diabetes
□ Stroke	□ Bleeding Tendency	□ Asthma	□ Thyroid disease
□ Colitis	□ Alcoholism		

Social History:

Marital Status:
□ Never married □ Married □ Divorced/Separated □ Widowed
Education:
□ Grade School □ Jr. High School □ High School □ College □ Graduate School
Occupation:_____ Average number of hours per week:_____
Home conditions:
Do you have stairs to climb? _____ How many? _____
Number of people in household: _____ Relationship and age of each: _____
_____

On the scale below, check the box beside the number which best describes your situation.
Most of the time I function:
□ 1 - Very poorly □ 2 - Poorly □ 3- OK □ 4- Well □ 5 - Very well

Because of health problems, do you have difficulty: (please check the appropriate response):

	Usually	Sometimes	Never
Using your hands to grasp small objects:	□	□	□
Walking	□	□	□
Climbing Stairs	□	□	□
Descending Stairs	□	□	□
Sitting Down	□	□	□
Getting up from a chair	□	□	□
Reaching behind your back or head	□	□	□
Dressing yourself	□	□	□
Going to sleep	□	□	□
Staying asleep due to pain	□	□	□
Obtaining restful sleep	□	□	□
Bathing	□	□	□
Eating	□	□	□
Working	□	□	□
With morning stiffness	□	□	□

Do you use a □ cane □ crutches □ walker or □ wheelchair?

What is the hardest thing for you to do?_____
Are you receiving disability?_____ Are you applying for disability?_____

Systems Review:

General:

☐Recent weight loss/gain ☐Fatigue ☐Weakness ☐Fever
☐Chills ☐Sweating ☐Anorexia

Eyes:

☐Pain ☐Loss of vision ☐Discharge ☐Blurring
☐Irritation ☐Light sensitivity ☐Double vision

Ears/Nose/Throat:

☐Ear pain/discharge ☐Ringing ☐Decreased hearing
☐Nasal obstruction/discharge ☐Nosebleeds ☐Sore-throat
☐Hoarseness ☐Difficulty swallowing

Cardiovascular:

☐Chest pain ☐Palpitations ☐Peripheral swelling
☐Shortness of breath when lying down ☐Shortness of breath with activity

Respiratory:

☐Cough ☐Shortness of breath ☐Excessive sputum ☐Wheezing
☐Coughing up blood

Stomach/Intestines:

☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation
☐Abdominal pain ☐Stool containing blood ☐Jaundice

Kidney/Bladder/Genitals:

☐Trouble urinating ☐Excessive urination at night
☐Urine containing blood ☐Impotence ☐Discharge ☐Hesitancy
☐Incontinence ☐Genital sores ☐Decreased libido

Musculoskeletal:

☐Back pain ☐Joint pain ☐Joint swelling
☐Muscle cramps ☐Muscle weakness ☐Stiffness

Skin:

☐Rash ☐Itching ☐Dryness ☐Suspicious lesions

Nervous system:

☐Transient paralysis ☐Weakness ☐Numbness/Tingling
☐Seizures ☐Lapse in consciousness ☐Tremors ☐Vertigo

Psychiatric:

☐Mental disturbances ☐Suicidal ideas ☐Hallucinations
☐Paranoia

Endocrine:

☐Cold intolerance ☐Heat intolerance ☐Excessive thirst
☐Excessive hunger ☐Excessive urination ☐Weight change

Blood/Lymphatic:

☐Abnormal bruising ☐Abnormal bleeding
☐Lymph node enlargement

Allergies/Immune system:

☐Red dots on the skin ☐Hay fever ☐HIV exposure
☐Persistent infections