Coastal Arthritis and Rheumatism Associates

PATIENT REGISTRATION

Date:________

Chart#_______

Patient's Full Name: ____
Last First Middle

Home Phone: ____________________ Sex: ☐M ☐F Date of Birth:____/____/______

Cell Phone: ____________________

Home Address: ____
Street City State Zip

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 Medicare Part D:____
ID# __________________________ Group# _________________
Insured's Name: ___________________________ DOB:_____________SS#_________________
Relationship to Insured: ________________________

PLEASE PRESENT YOUR INSURANCE CARDS TO THE WINDOW

Patient Employer: ____
Address: ____

Spouse's Name: ______________________________
Spouse's Employer: ________________________ Covered by their Insurance: ☐ Y ☐ N

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: ___/___/___ Race: _____________ Ethnicity:____________

Referred here by: □ Self □ Family □ Doctor □ Other
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 including Rheumatologists and Pain Management Physicians:

____

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

	relation		relation
□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:______________________________

____

Drug allergies? _____________ To what?___________________________

Type of reaction:____

Menstrual History (if applicable):
Age when periods began: _______ Are they regular? _____ Date of last period: _______
Number of: pregnancies:___ live births: ___ Miscarriages: ___ Elective Abortions: ___

Habits:

Do you use tobacco products? ___ Smoke ___ Chew ___ Vape ___

If smoke tobacco products, how many packs per day on average? ______

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? ______________________________________

Present Medications:
list all medications you are taking at this time, or include a list from your doctor's office.

Name of Drug	Dose (strength and frequency)	Results Scale
		no results 0 — 5 — 10 good results
1.		*
2.		*
3.		*
4.		*
5.		*
6.		*
7.		*
8.		*
9.		*
10.		*
11.		*
12.		*
13.		*
14.		*
15.		*
16.		*
17.		*
18.		*
19.		*
20.		*

Over the counter medications, supplements, vitamins:

Past Medications: Please review these examples of the following "Arthritis" medications and tell us if you had any benefits from those you have tried in the past. Include any side effects noted. Both brand name and generic names have been given in some cases.

Non-Steroidal Anti inflammatory Medications:
Celebrex/celecoxib, Clinoril, Daypro, Feldene, Indocin/indomethacin, Lodine, Motrin/ibuprofen, Mobic/meloxicam, Naprosyn/naproxen, Relafen/nabumetone, Voltaren/diclofenac

Results: ____
____
____
____

Disease Modifying Agents:
Arava/lefunomide, Azulfidine/sulfasalazine, Cellcept/mycophenolate, cyclosporin, cytoxan, Imuran/azathioprine, methotrexate, Plaquenil/hydroxychloroquine

Results: ____
____
____
____

Injectable/Infusion Biologic Response Modifiers:
Actemra/tocilzumab, Benlysta/belimumab, Cimzia/certolizuab, Cosentyx/secukinumab, Enbrel/enteracept, Humira,/ adalimamab, Ilaris/canakinumab, Kevzera/sarilumab, Orencia/abatacept, Remicade/infliximab, Rituxan/rituximab, Saphnelo/anifrolumab, Taltz/ixekizumab

Results: ____
____
____
____

Oral Biologic Response Modifiers:
Olumiant/baricitinib, Rinvoq/upadacitinib, Xeljanz/tofacitinib

Results: ____
____
____
____

Miscellaneous:
Steroids (Prednisone or Medrol)
allopurinol, colchicine, Uloric/febuxostat

Results: ____

Controlled Pain Medications (please list drugs you have taken):
Controlled medications and any results or side effects:
____
____
____
____

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 High School College Graduate School
Occupation:______________________ Average number of hours/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?_________________________________