SCENIC CITY
RHEUMATOLOGY, PLLC

PATIENT DEMOGRAPHICS

Last:	**First:**		**Middle:**	
Name you Prefer:	**Birth Sex:** M F	**Social Security:**	**Marital Status:** S M D W	**Date of Birth:**
(Please Circle)	**African American / American Indian / Asian / Native Hawaiian or Pacific Islander / White / Other**			
(Please Circle)	**Hispanic or Latinx / Non-Hispanic or Non-Latinx / Unknown**			
Mailing Address:				
City:		**State:**	**Zip Code:**	
Home Phone:		**Cell Phone:**	**Office Phone:**	
Which is your preferred phone number we should call? ○ **Home** ○ **Cell** ○ **Office**		**E-Mail Address:**		
Occupation: ○ **Employed (current work)** _____ ○ **Unemployed** ○ **Student** ○ **Military** ○ **Homemaker** ○ **Retired (previous work)** _____ ○ **Disabled: How long? Why?** _____				

PHARMACY INFORMATION

Local Pharmacy:	**Local Pharmacy Phone:**
Local Pharmacy Address:	
Mail Order Pharmacy:	

INSURANCE INFORMATION

Primary Insurance:	**Subscriber's Full Name:**	
Relationship:	**Subscriber's Social Security:**	**Subscriber's Date of Birth:**
Secondary Insurance:	**Subscriber's Full Name:**	
Relationship:	**Subscriber's Social Security:**	**Subscriber's Date of Birth:**

Patient Name _____ Date of Birth _____

OTHER PHYSICIANS INVOLVED IN YOUR CARE		
Physician's Name:	**Specialty:**	**Office Name or Phone:**
	Primary Care Physician (required)	

EMERGENCY CONTACT		
Name:	**Phone:**	**Relationship:**

RELEASE OF HEALTHCARE INFORMATION

Scenic City Rheumatology strongly believes in protecting your confidentiality. However, we do need to be able to contact you with vital information concerning your healthcare or for appointment reminders. When contact is necessary, we will always try to speak directly with you or your personal representative first. It may sometimes be necessary to leave a message on an answering machine or voice mail at a telephone number you have provided us or with another member of your family/household.

* May we leave a message on your home phone? YES _____ NO _____
* May we leave a message on your cell phone? YES _____ NO _____
* May we leave a message on your office phone? YES _____ NO _____

Who else may we speak with or leave a message with regarding your care?

Name_____ Phone_____ Relationship_____
Name_____ Phone_____ Relationship_____

AUTHORIZED SIGNATURE _____

Patient Printed Name _____

Relationship if not Patient _____

Patient Name _____ Date of Birth _____

CONSENT FOR TREATMENT AND HEALTHCARE OPERATIONS

I am aware that a copy of Scenic City Rheumatology's Privacy Practices are posted in the lobby and I have the right to review that notice before signing this consent. Scenic City Rheumatology may change privacy practices at any time if necessary and will post a revised copy in the lobby, or I may request a copy to be given to me at any time.
I consent to the use or disclosure of my protected health information by Scenic City Rheumatology for the purpose of diagnosing or providing treatment or to conduct the health care operations of Scenic City Rheumatology. I authorize any holder of medical or other information about me to be released to my insurance company for this or any other related medical claim(s).

FINANCIAL POLICY

I request payment of medical insurance benefits to Scenic City Rheumatology, PLLC. I understand that the charges I incur are my responsibility. I understand that it is my responsibility to know if my physician is in any network plan. If my insurance company fails to make payment in a timely manner, I am responsible for this bill. I understand that any attorney, court, and collection fees will be my responsibility.

NO SHOW POLICY

Patient will be charged $50.00 for no-show appointments. Patient is responsible for this fee, as insurance will **NOT** cover charges for no-show appointments.

AUTHORIZED SIGNATURE _____

Patient Printed Name _____

Relationship if not Patient _____

Patient Name _____ Date of Birth _____

NEW PATIENT HISTORY

Describe briefly your present symptoms:

_____

_____

Date symptoms began (approximate): _____

Previous treatment for this problem (e.g. physical therapy, chiropractic, medications, injections, surgeries, etc.)

_____

_____

PAST MEDICAL HISTORY: Please circle all your medical problems that apply.

Anemia / Low blood counts
Anxiety / Depression
Asthma / COPD / Emphysema
Bleeding disorder
Blood clots / DVT
Cancer; specify type and treatment
Chronic Fatigue Syndrome
Crohn's / Ulcerative colitis
Diabetes Type 1 or Type 2
Epilepsy / Seizure Disorder
Fibromyalgia
GERD / Hiatal Hernia
Gout / Pseudogout
Hearing Problems
Heart Disease-Specify: Arrhythmia, Heart Failure, Coronary Artery Disease, Heart Attack, Valve Disease
High cholesterol
Hypertension
Immunodeficiency
Infectious Diseases (Chronic); please specify
Kidney Disease
Kidney Stones
Liver Disease
Lupus / SLE / Connective Tissue Disease
Osteoarthritis
Osteoporosis / Osteopenia
Pacemaker
Peptic Ulcer Disease
Peripheral Vascular Disease
Psoriasis / Psoriatic Arthritis
Raynaud's
Rheumatoid Arthritis
Sleep Apnea
Thyroid Disease: Hyper / Hypo
Tuberculosis
Other: _____
Other: _____

PREVIOUS SURGERIES:

PROCEDURE	DATE
1	
2	
3	

PROCEDURE	DATE
4	
5	
6	

Have you ever had a DEXA (bone density study)? Approximate date/findings? _____

When was your last eye exam? _____

Any previous fractures? If so, please describe:_____

Other serious injuries? If so, please describe: _____

Are you up to date on vaccines? Yes No List approximate dates of the following vaccines, if applicable:

Influenza vaccine:	Shingles:
Pneumonia vaccine(s):	COVID 19:
Other:	Other:

Have you been screened for tuberculosis? List approximate date/result_____

Patient Name _____ Date of Birth _____

FAMILY HISTORY:

	Mother	Father	Sister	Brother	Daughter	Son
Arthritis (specify type if known)						
Bleeding Disorder						
Cancer						
Dementia						
Diabetes (type 1/type 2?)						
Gout						
Heart Disease						
Hypertension						
Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)						
Lupus / SLE						
Multiple Sclerosis						
Muscle Disease / Myopathy						
Osteoporosis						
Psoriasis / Psoriatic Arthritis						
Stroke						
Substance abuse / Alcoholism						
Thyroid disease (hypo/hyper?)						
Tuberculosis						

SOCIAL HISTORY: Please indicate/explain the following:

Do you have support at home? Who _____ Live alone?

Number of children: _____

Education (circle highest level attended): Grade School 7 8 9 10 11 12 College (1 2 3 4) Graduate School
Other Training _____

Have you applied or are you applying for disability? Yes No

Hobbies/activities _____

Do you drink caffeinated beverages? Yes No Cups/glasses per day? _____ Coffee/Tea/Soda/Other_____

Do you smoke? Yes No Previous smoker? Quit date (approximate) _____

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 _____

Average # of hours you sleep nightly? _____ Wake up feeling rested/refreshed? Yes No

Patient Name _____ Date of Birth _____

REVIEW OF SYSTEMS: Circle symptoms that you have experienced recently

CONSTITUTIONAL: Chills, fatigue, fever, unintended weight loss
EYES: Blurred vision, eye pain, dry eyes
EAR/NOSE/THROAT: Runny nose, dry mouth, oral or nasal sores/ulcers
CARDIOVASCULAR: Chest pain, palpitations, hands turn white when cold
RESPIRATORY: Cough, shortness of breath, exposure to tuberculosis
GI: Difficulty swallowing, constipation, diarrhea, heartburn, bloody stools, black stools, nausea, vomiting
GENITOURINARY: Painful urination, difficulty urinating, blood in urine, genital sores
MUSCULOSKELETAL: Joint pain, back pain, joint stiffness, muscle aches, joint swelling, neck pain
SKIN: Rash, sun-induced skin sensitivity
NEUROLOGIC: Unsteady gait, dizziness, headaches, memory loss, numbness/tingling, seizures
HEMATOLOGIC/LYMPHATIC: Easy bruising, excessive bleeding, enlarged lymph nodes
ENDOCRINE: Hair loss, abnormal thyroid, abnormal blood sugar
PSYCHIATRIC: Anxiety, depression, difficulty concentrating, sleep disturbance

DISEASE/FUNCTIONAL MEASURES:

We are interested in learning how your illness affects your ability to function in daily life. **Place an X in the box which best describes your usual abilities OVER THE PAST WEEK.** Are you able to:

	Without Any 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/off toilet?				
Reach and get down a 5 pound object (such as a bag of sugar) from just above your head?				
Open car doors?				
Do outside work (such as yard work)?				
Wait in line for 15 minutes?				
Lift heavy objects?				
Move heavy objects?				
Go up two or more flights of stairs?				

Please circle responses to the following:

Level of <u>FATIGUE</u> IN THE PAST WEEK: **(none) 0 1 2 3 4 5 6 7 8 9 10 (worst possible)**

What is your current level of <u>PAIN</u>: **(none) 0 1 2 3 4 5 6 7 8 9 10 (worst possible)**

Considering all the ways your arthritis affects you, rate how well you are doing on the following scale.

Current rheumatic <u>DISEASE ACTIVITY</u>: **(none) 0 1 2 3 4 5 6 7 8 9 10 (worst possible)**

Patient Name _____ Date of Birth _____

MEDICATIONS

Please list all prescription medications and supplements with doses or submit your current, accurate medication list.

Medication	Dose/Times Per Day	Prescriber

ALLERGIES

Medication	Reaction

☐ I have no known drug allergies.

STOP! DO NOT WRITE BELOW THIS LINE

DO NOT DRAW ON THE SKELETON

FOR OFFICE USE ONLY *** FOR OFFICE USE ONLY ***** FOR OFFICE USE ONLY ***** FOR OFFICE USE ONLY**

BP	HR	WT	Other:
HT	TEMP	R	
O2