SouthWest Arthritis Research Group, P.A.
1600 Republic Parkway, Suite 200
Mesquite, TX 75150

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www.myarthritisdoc.com

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Welcome to our office and thank you for trusting us with your healthcare needs.

Please read the following information, then complete the attached new patient packet as best you can and bring it with you to your first appointment.

Having all pertinent medical records available at your first visit will ensure that your appointment is as productive as possible. You may receive a call from our office if we haven't received records prior to your appointment date.

1. Please arrive 15 minutes prior to your appointment. If you need assistance filling out your new patient forms, please arrive 30 minutes prior to your appointment.
2. Bring your Driver's License (or other ID) and Insurance Cards
3. If you need to cancel or reschedule, please call at least 48 hours in advance so we can offer your appointment to another patient in need of care.
4. We welcome patients with ALL insurance plans, as well as uninsured patients. Our goal is to make sure all patients receive the care they need, regardless of their insurance status or ability to pay.
5. If you are going to be late for your appointment, please call us as soon as possible. We will try our best to accommodate late arrivals. At times, it may be necessary to reschedule your appointment.
6. Patients are seen in the order of their appointment with their scheduled physician. Please be advised that we have several departments within our clinic. If you see a patient being called back before you, it does not necessarily mean you're being skipped.
7. Please bring any past medical records and recent lab results with you. You can request medical records to be directly mailed or faxed to us by completing the enclosed "Authorization for Release of Records".
8. If blood work or x-rays are necessary during the consultation, they will usually be performed at our office unless you prefer a different location. If outside testing is ordered, you may receive a bill from that facility.
9. Normal test results will be discussed at your next visit. We will only call you to discuss critical results.
10. If you are taking any medications, please bring all **MEDICATION BOTTLES** with you to your appointment. We cannot reference any medication off of a medication list. We must have the actual bottle(s).
11. **We do not prescribe narcotic pain killers and we do not fill out any disability or DME forms.**

If you have any questions, need directions to our office, or if you're unable to keep this appointment, please call us at 972-288-2600 or email us at appointments@myarthritisdoc.com

We look forward to seeing you!

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Demographic Form

Patient Information

Patient Last Name	*First Name*	*Middle Name*	*Preferred Name*
Address			
Home Phone	*Cell Phone*	*Work Phone*	*Preferred Number: Home / Cell / Work*
Email (Please Print Clearly in Uppercase)		*Marital Status* Single Married Divorced Widow	
Social Security Number		*Sex* Male Female	*Date of Birth*
Primary Care Physician Name & Address		*Phone #*	*Fax #*
Referring Physician Name & Address		*Phone #*	*Fax #*

Insurance Information

Primary Insurance		*Secondary Insurance*	
Policy ID #	*Group ID #*	*Policy ID #*	*Group ID #*
Subscriber Name	*Date of Birth*	*Subscriber Name*	*Date of Birth*
Subscriber Social Security Number	*Relationship to Patient*	*Subscriber Social Security Number*	*Relationship to Patient*

Assignment of Medical Benefits

I hereby assign all medical benefits to which I am entitled, private insurance and other health plan to Southwest Arthritis Research Group, P.A. *This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for all charges whether or not paid by said insurance company. I hereby authorize said assignee to release all information necessary to secure payment on my behalf.*

Signature ______________________ Date ______________

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Patient Communication Questionnaire for HIPAA Compliance

My preferred method of communication regarding my medical condition, appointment reminders, and billing is:

□ Home Phone

□ Cell Phone ____

□ Work Phone

May we leave a message? YES NO

* *Updates to contact information must be made in writing*

Do you want to receive appointment reminders by text message? YES NO

If yes, cell phone number: ___________________________________

Do you want access to our online patient portal? YES NO

If yes, email address: ____

Keeping your information private is important to us. We will only disclose your information to YOU, except in emergency situations.

You may authorize us to disclose medical, billing, or other information to additional contacts below.

In case of emergency:

Contact Name	Relationship to Patient	Contact Phone Number

Other Authorized Contacts:

Contact Name	Relationship to Patient	Contact Phone Number

Information to disclose: □ medical condition □ billing account □ other:

Contact Name	Relationship to Patient	Contact Phone Number

Information to disclose: □ medical condition □ billing account □ other:

1. I acknowledge that a HIPAA Privacy Policy has been made available to me for review in the waiting room area and exam rooms. (If unable to locate a copy please see a member of our staff.)
2. If I am ever in an unsecured area within the practice and I require privacy for any reason, I will request to be moved to a private area to complete my needed transactions or correspondence (financial, treatment plan, diagnosis, etc.).

Patient Name (Please Print)	Signature	Date

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INITIAL VISIT: *Please answer each section by either writing in the space below or circling one of the options listed. This information is CONFIDENTIAL and will not be released without your permission.*

Your Name:______________________________ Date of Birth______________________

Your Doctor:______________________________ Doctor's Phone # ____________________

Your Doctor's Address____

Who do you want information/reports sent to? *(circle)* Yourself Family MD Other MD

ABOUT YOUR ARTHRITIS:

What are your problems? ____

Symptoms First Began: Month/Year ______________

Most Affected Areas *(circle)*: HANDS FEET SHOULDERS KNEES HIPS BACK NECK

First Diagnosed As:______________________________By Dr. ____________________

Have you ever been seen by a Rheumatologist? Yes or No If yes, Dr.______________________

I HAVE BEEN TOLD THAT I HAVE:

□ LUPUS	□ PSORIASIS/PSORIATRIC ARTHRITIS	□ GOUT
□ OSTEOARTHRITIS	□ RHEUMATOID ARTHRITIS	□ FIBROMYALGIA
□ SCLERODERMA	□ POLYMYOSITIS	□ VASCULITIS
□ SPONDYLITIS	□ JUVENILE RHEUMATOID ARTHRITIS	□ SJOGREN'S

Abnormal Tests *(circle)*: ANA SedRate (ESR) RF(rheumatoid factor) Uric Acid

My sleep is *(circle)*: Great Normal Fair Poor Very Poor Wake Up Tired

Do you have Morning Joint/Muscle Stiffness or Pain? *(circle)*: Yes or No

How long does this Stiffness or Pain last? *(circle)*: 15min 30min 45min 1hr 2hr 4hr

OTHER MEDICAL PROBLEMS: *(check all that apply)*

□ Diabetes	□ Lung disease	□ HEPATITIS B or C	□ Thyroid problems
□ Hypertension	□ Asthma	□ Psoriasis	□ Joint surgery
□ Heart Disease	□ Stomach ulcers	□ Bleeding ulcers	□ Plastic surgery
□ Stroke	□ Colitis	□ Osteoporosis	□ Fractures
□ Irregular heartbeat	□ Kidney disease	□ Depression	□ Hospitalization

DO YOU HAVE: *(now or in the past)*

□ Weight loss	□ Memory loss	□ Ringing in ears	□ Difficulty sleeping
□ Weight gain	□ Skin ulcers	□ Depression	□ Hemorrhoids
□ Fever	□ Hives	□ Jaw pain	□ Jaundice
□ Weakness	□ Itching	□ Hearing problems	□ Chest pain
□ Fatigue	□ Hair falling out	□ Swollen glands	□ Cough
□ Night sweats	□ Abnormal nails	□ Peptic ulcers	□ Shortness of breath
□ Joint pains	□ Easy bruising	□ Heartburn	□ Wheezing
□ Swollen joints	□ Sores in mouth	□ Indigestion	□ Purple/white fingers
□ Muscle pain	□ Dental problems	□ Nausea	□ Swelling in legs/feet
□ Tendonitis	□ Dry mouth	□ Vomiting	□ Lower back pain
□ Bursitis	□ Dry eyes	□ Swallowing problems	□ Red "pink" eyes
□ Gastritis	□ Eye pain	□ Heel pain	□ Menopause
□ Nodules (knots)	□ Vision problems	□ Diarrhea	□ Numbness
□ Skin rash	□ Menstrual problems	□ Constipation	□ Discharge (vaginal or penile)
□ Psoriasis	□ Nosebleeds	□ Diverticulitis	
□ Tight skin	□ Chronic sinusitis	□ Blood in stool	□ Painful urination

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Name:____ Date of Birth: _____________________________

List All Current Medications:____
____
____

List Your Vitamins/Supplements: ____
____

What Are You Allergic To?: ____

Have You Ever Taken Any of These Medications? *(check all that apply)*:

DMARDs	BIOLOGICS	NSAIDs	OSTEOPOROSIS
□ *Hydroxychloroquine (Plaquenil)*	□ *Abatacept (Orencia)*	□ *Naproxen (Aleve)*	□ *Fosamax (Alendronate)*
□ *Sulfasalazine (Azulfidine)*	□ *Rituximab (Rituxan)*	□ *Anaprox (Naprosyn)*	□ *Actonel*
□ *Leflunomide (Arava)*	□ *Golimumab (Simponi)*	□ *Ibuprofen (Advil/Motrin)*	□ *Boniva*
□ *Methotrexate*	□ *Actemra*	□ *Aspirin*	□ *Zoledronic Acid (Reclast/Zometa)*
□ *Cyclosporine*	□ *Humira*	□ *Diclofenac*	□ *Evista*
□ *Cyclophosphamide*	□ *Certolizumab (Cimzia)*	□ *Celecoxib (Celebrex)*	□ *Forteo*
□ *Mycophenolate (Cellcept)*	□ *Etanercept (Enbrel)*	□ *Indomethacin (Indocin)*	□ *Calcitonin*
□ *Otezla*	□ *Infliximab (Remicade)*	□ *Ketorolac (Toradol)*	□ *Prolia*
□ *Other:*	□ *Stelara*	□ *Piroxicam (Feldene)*	□ *Other:*
	□ *Tofacitinib (Xeljanz)*	□ *Other:*	
	□ *Other:*		

Work, Lifestyle & Family:

Current Job: ______________________________________ Employer: ____

Stress Level: __________________________

Marital Status: Single Married Divorced Separated Widowed Other:____________

Who lives with you?____

Pets at home? Yes or No

Foreign Travel? Yes or No If Yes, Where?____

Do you smoke? NEVER NO *(quit ______ years ago)* YES *(packs per day? ______)*

Do you drink alcohol? NEVER I QUIT RARELY SOCIALLY DAILY

Hepatitis B or C Risk Factors: *(circle all that apply)* Blood Transfusions Contact w/ blood or bodily fluids Tattoos or Body Piercing Shared razor or toothbrush Multiple sexual partners

Does anyone in your family have ARTHRITIS?____

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Name:____ Date of Birth: ___________________________

In the PAST WEEK, how much PAIN have you experienced? *(provide a number)*

NO PAIN 0 --10 MOST SEVERE PAIN

AT THIS MOMENT, ARE YOU ABLE TO: *(place a check in the appropriate box)*	No difficulty	Some difficulty	Much difficulty	Cannot Do
1. Dress yourself, including shoelaces/buttons?				
2. Get in and out of bed?				
3. Lift a full glass or cup to your mouth?				
4. Walk outdoors on flat ground?				
5. Wash and dry your entire body?				
6. Bend down and pick up clothing from the floor?				
7. Turn regular faucets on and off?				
8. Get in and out of a car?				
9. Walk two miles or three kilometers, if you wish?				
10. Participate in recreational activities and sports as you would like, if you wish?				
11. Get a good night's sleep?				
12. Deal with feelings of anxiety or being nervous?				
13. Deal with feelings of depression or feeling blue?				

Considering all the ways in which illness and health conditions may affect you at this time, please indicate how you are doing today: *(provide a number)*

BEST 0 --10 WORST

SouthWest Arthritis Research Group, P.A. offers several CLINICAL DRUG TRIALS through pharmaceutical companies and we would like to offer these opportunities to you.

May we contact you to discuss CLINICAL DRUG TRIALS?

YES NO

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Confidential Health Information Enclosed

This fax contains confidential health care information that is personal and sensitive information. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, may be obligated under Federal or State Law to maintain the information in a safe, secure and confidential manner. Re-disclosure without additional patient permission or as otherwise permitted by law may be prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties under Federal Law.

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Authorization for Release of Records

The undersigned hereby authorizes and requests Dr. ____

to provide *SouthWest Arthritis Research Group* with access to the medical and treatment records of

*(name)*____________________________________ *(date of birth)* ______________________ for the purpose

of continuing treatment. I release you from all legal responsibility or liability that may arise from this authorization.

Signed: ____ Date: _____________________________

Witness: ____

Important Warning: *This message is intended for use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is* **STRICTLY PROHIBITED***. If you have received this message in error, please notify us immediately and destroy the related message.*