

Appointment Checklist (please bring the following to your appointment):

1. Completed patient information forms (included in this packet)
2. Insurance Card(s)
3. Driver's License or valid photo ID
4. Claim Information (if auto or worker's compensation injury)
5. Copay/Deductible Payment
6. Primary Care Referral (if applicable)
7. Any applicable imaging studies done in the past year (includes X-rays, MRI's, CT scans, and EMG's)

Patient Guidelines:

Thank you for choosing us as your healthcare provider. It is our mission to provide you with an exceptional patient experience and return you to your activities as quickly and safely as possible. Please help us in our mission to provide high quality, integrated care by adhering to the following policies while in our facility:

1. **Check-in** – Check in at the front desk prior to each appointment. Your copay will be collected prior to your appointment and will make a copy of your insurance card.
2. **Check-out** – All patients must check out after each appointment regardless of if a follow-up appointment is necessary.
3. **Copays** – Your copay is due at the time of your appointment. If you do not have your copay, your appointment will be rescheduled. If your insurance changes during the course of your treatment let us know right away so you do not get billed for any unpaid balances.
4. **Referrals** – If your insurance requires a referral, it is your responsibility to bring it with you. You will be responsible for payment of your office visit if you do not have it.
5. **Appointment Times** – If you are 10-15 minutes late for your appointment time, you may be asked to reschedule your appointment. If you know in advance you will be running late, please call and let us know. Being early is helpful, but it does not mean you will be taken back early.
6. **Monitor Children** – If you do bring children to your appointment, we ask that you supervise them and do not leave them alone in the waiting room.
7. **Cell Phones** – Refrain from using your cell phone during your appointment when you are with physician, clinician or other member of our staff.
8. **Form Fee** – There is a \$15 fee for all disability or FMLA forms that need to be completed by a doctor. Allow 5-7 business days for your form to be completed. You will be contacted when they are ready.



Rheumatology Patient History

Date of first appointment _____

Name (*Last, First, Middle Initial*) _____ Birthdate ____/____/____ Age _____

Sex: M F Telephone: Home _____ Work _____

Marital Status: Never married Married Divorced Separated Widowed

Spouse/Significant Other: Alive/Age _____ Deceased/Age _____ Major Illnesses _____

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

Occupation _____ # 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 physician providing your primary medical care: _____

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

Describe briefly, your present symptoms: _____
_____ Date symptoms began (*approx*): _____

Diagnosis: _____

Previous treatment for this problem – include physical therapy, surgery & injections (*medications to be listed later*):

List names of other practitioners you have seen for this problem: _____

Rheumatologic (Arthritis) History *At any time have you or a blood relative had any of the following?*

	Self	Relative/relationship		Self	Relative/relationship
Arthritis (unknown)	<input type="checkbox"/>	<input type="checkbox"/> _____	LUPUS or SLE	<input type="checkbox"/>	<input type="checkbox"/> _____
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/> _____	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> _____
Gout	<input type="checkbox"/>	<input type="checkbox"/> _____	Ankylosing Spondylitis	<input type="checkbox"/>	<input type="checkbox"/> _____
Childhood Arthritis	<input type="checkbox"/>	<input type="checkbox"/> _____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/> _____

Patient's Name _____ Date _____ Physician initials _____

Systems Review

As you review the following list, please check any of those problems which have significantly affected you.

Constitutional

- Recent weight GAIN Amt. _____
- Recent weight LOSS Amt. _____
- Fatigue
- Weakness
- Fever

Eyes

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Feels like something in eye
- Itching eyes

Ears, Nose, Mouth, Throat

- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Dryness in nose
- Runny nose
- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness of mouth
- Frequent sore throats
- Hoarseness
- Difficulty swallowing

Cardiovascular

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- High blood pressure
- Heart murmurs

Respiratory

- Shortness of breath
- Difficulty breathing at night
- Swollen legs or feet
- Cough
- Cough up blood
- Wheezing (asthma)

Gastrointestinal

- Nausea
- Vomiting blood/coffee ground material
- Stomach pain relieved by food or milk
- Jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools
- Heartburn

Genitourinary

- Difficult urination
- Pain/burning on urination
- Blood in urine
- Cloudy, smoky urine
- Pus in urine
- Discharge from penis/vagina
- Getting up at night to pass urine
- Vaginal dryness
- Rash/ulcers
- Sexual difficulties
- Prostate trouble

For WOMEN only

- Age when period began _____
- Periods regular? No Yes
- How many days apart? _____
- Date of last period? _____
- Date of last pap? _____
- Bleeding after menopause? No Yes
- Number of pregnancies? _____
- Number of miscarriages? _____

Musculoskeletal

- Morning stiffness lasting how long?
_____ minutes _____ hours
- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling
(List joints affected in the last 6 months)

Integumentary/skin or breast

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive (sun allergy)
- Tightness
- Nodules/bumps
- Hair loss
- Color changes in hands and/or feet in the cold

Neurological System

- Headaches
- Dizziness
- Fainting
- Muscle Spasm
- Loss of consciousness
- Sensitivity or pain in hands and/or feet
- Memory loss
- Night sweats

Psychiatric

- Excessive worries
- Anxiety
- Easily losing temper
- Depression
- Agitation
- Difficulty falling asleep
- Difficulty staying asleep

Endocrine

- Excessive thirst

Hematologic/Lymphatic

- Swollen glands
- Tender glands
- Anemia
- Bleeding tendency
- Transfusion – when? _____

Allergic/Immunologic

- Frequent sneezing
- Increased susceptibility to infection

Patient's Name _____ Date _____ Physician initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages? No Yes If yes, cups/glasses per day? _____
Do you smoke? No Yes Past How long ago? _____
Do you drink alcohol? No Yes How many drinks per week? _____ Has anyone ever told you to cut down on your drinking? No Yes
Do you use drugs for reasons that are not medical? No Yes If yes, please list: _____
Do you exercise regularly? No Yes If yes, type: _____ Amount per week: _____
How many hours of sleep do you get at night? _____ Do you get enough sleep at night? No Yes Do you wake up feeling rested? No Yes

PAST MEDICAL HISTORY Do you now or have you ever had? (*check if yes*)

- | | | | | | |
|------------------------------------|------------------------------------|--|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Goiter | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Nervous breakdown | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Headaches, severe | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Tuberculosis |

Other significant illnesses (*please list*): _____

Natural or Alternative Therapies (magnets, chiropractic, massage, over the counter preparations etc.) _____

TESTING

Date of last Dexa Scan	_____	Date of last Colonoscopy	_____
Date of last Chest X-ray	_____	Date of last Pap	_____
Date of last TST	_____	Date of last PSA	_____
Date of last Mammogram	_____	Date of last Flu Vaccine	_____

PREVIOUS OPERATIONS

Type	Year	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any previous fractures: No Yes If yes, please describe: _____

Any other serious injuries? No Yes If yes, please describe: _____

Family History

	<i>If Living</i>	<i>If Deceased</i>
Father	Age _____ Health _____	Age of Death _____ Cause _____
Mother	Age _____ Health _____	Age of Death _____ Cause _____
Siblings	How Many _____ Living _____	Number Deceased _____
Children	How Many _____ Living _____	Number Deceased _____ List ages of each _____
	Health of children _____	

Do you know of any blood relative who has or had (*check & give relationship*):

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Leukemia _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Psoriasis _____ |
| <input type="checkbox"/> Bleeding tendency _____ | <input type="checkbox"/> Goiter _____ | <input type="checkbox"/> Rheumatic Fever _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Colitis _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Tuberculosis _____ |

Patient's Name _____ Date _____ Physician initials _____

DRUG ALLERGIES: No Yes If yes, to what? _____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking such as aspirin, vitamins, laxatives, calcium & other supplements)

Name of medication supplement/vitamin, etc.	Dose (include strength and # of pills per day)	How long have you been taking this?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICATIONS (Please review the list of arthritis medications. As accurately as possible, try to remember which medications you have taken, how long you took the medication, the results of taking the medication & list any reactions you may have had.)

Drug Names/Dosage	Length of Time Taken	Helped			Reactions
		A Lot	Some	Not at all	
Pain Relievers					
Acetaminophen (Tylenol)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Codeine (Vicodin, Tylenol 3)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Propoxyphene (Darvon/Darvocet)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Disease Modifying Antirheumatic Drugs (DMARDS)					
Adalimumab (Humira)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Auranofin, gold pills (Ridaura)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Azathioprine (Imuran)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cyclophosphamide (Cytoxan)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cyclosporine A (Sandimmune or Neoral)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Etanercept (Enbrel)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gold shots (Myo-chrysin or Solganol)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hydroxychloroquine (Plaquenil)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infliximab (Remicade)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Methotrexate (Rheumatrex)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Penicillamine (Cuprimine or Depen)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sulfasalazine (Azulfidine)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient's Name _____ Date _____ Physician initials _____

PAST MEDICATIONS CONT'D

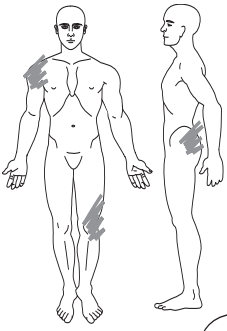
Drug Names/Dosage	Length of Time Taken	Helped			Reactions
		A Lot	Some	Not at all	
Osteoporosis Medications					
Alendronate (Fosamax)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Calcitonin injection or nasal (Miacalcin, Calicmar)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Estrogen (Premarin, etc.)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feraperatide (Forteo)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Raloxifene (Evista)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Risedronate (Actonel)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandromate (Boniva)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout Medications					
Allopurinol (Zyloprim/Lopurin)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colchicine	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Probenecid (Benemid)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Others					
Cortisone/Prednisone	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hyalgan/Synvisc injections	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tamoxifen (Nolvadex)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tiludronate (Skelid)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herbal or Nutritional Supplements	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list supplements: _____

Non-Steroidal Anti-Inflammatory Drugs (Check any drugs you have taken in the past)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Ansaid (ibuprofen) | <input type="checkbox"/> Daypro (oxaprozin) | <input type="checkbox"/> Lodine (etodolac) | <input type="checkbox"/> Oruvall (ketoprofen) |
| <input type="checkbox"/> Arthrotec (diclofenac, misoprosil) | <input type="checkbox"/> Disalcid (salsalate) | <input type="checkbox"/> Meclomen (meclofenamate) | <input type="checkbox"/> Tolectin (tolmetin) |
| <input type="checkbox"/> Aspirin (including coated aspirin) | <input type="checkbox"/> Dolobid (diflunisal) | <input type="checkbox"/> Motrin (ibuprofen) | <input type="checkbox"/> Trillisate (choline magnesium trisalicylate) |
| <input type="checkbox"/> Celebrex (celecoxib) | <input type="checkbox"/> Feldene (piroxicam) | <input type="checkbox"/> Nalfon (fenoprofen) | <input type="checkbox"/> Vioxx (rofecoxib) |
| <input type="checkbox"/> Clinoril (sulindac) | <input type="checkbox"/> Indocin (indomethacin) | <input type="checkbox"/> Naprosyn (naproxen) | <input type="checkbox"/> Voltaren (diclofenac) |

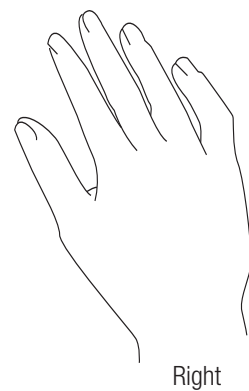
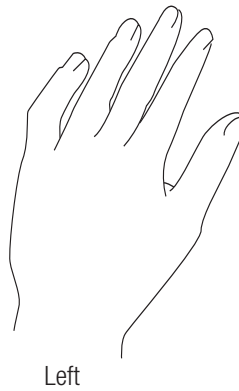
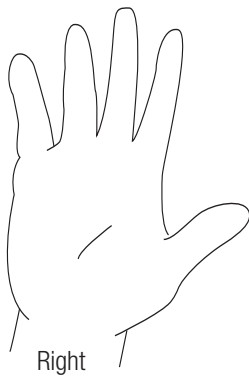
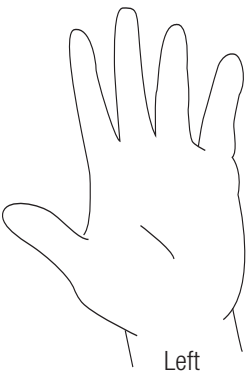
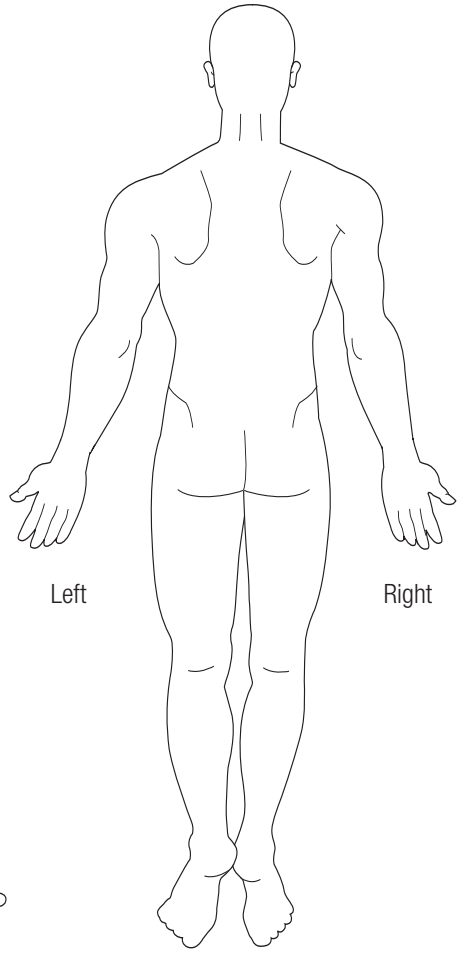
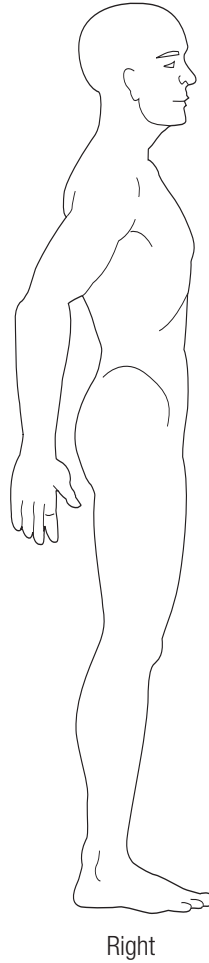
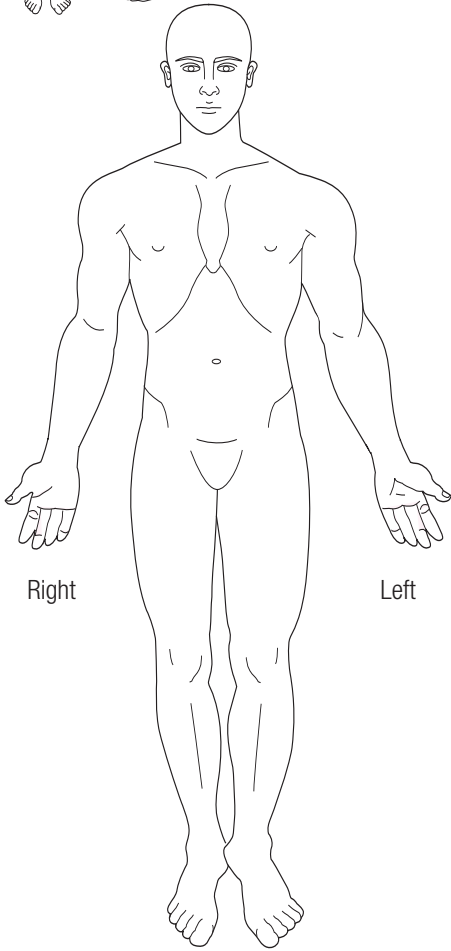
Patient's Name _____ Date _____ Physician initials _____



PAIN CHART

Please shade all the locations of your pain **over the last week** on the body figures and hands.

← Example





Coordinated Health

REVIEW OF SYSTEMS

Patient Name _____

Today's Date _____

Please answer the following questions to the best of your ability.

IN THE PAST 6 MONTHS:

	HAVE YOU HAD?		ARE YOU BEING TREATED BY A DR. FOR?	
General:				
1. Any recent unexplained changes in weight?	_____ NO	_____ YES	_____ NO	_____ YES
2. Any unexplained fevers?	_____ NO	_____ YES	_____ NO	_____ YES
3. Night sweats?	_____ NO	_____ YES	_____ NO	_____ YES
4. Any weakness or fatigue?	_____ NO	_____ YES	_____ NO	_____ YES
5. Loss of appetite?	_____ NO	_____ YES	_____ NO	_____ YES
6. Any immune deficiencies?	_____ NO	_____ YES	_____ NO	_____ YES
Musculo-skeletal:				
7. Any joint pain?	_____ NO	_____ YES	_____ NO	_____ YES
8. Joint swelling?	_____ NO	_____ YES	_____ NO	_____ YES
9. Muscle pain?	_____ NO	_____ YES	_____ NO	_____ YES
10. Muscle cramps?	_____ NO	_____ YES	_____ NO	_____ YES
11. History of back pain?	_____ NO	_____ YES	_____ NO	_____ YES
Skin:				
12. Any rashes?	_____ NO	_____ YES	_____ NO	_____ YES
13. Changes in skin?	_____ NO	_____ YES	_____ NO	_____ YES
14. Changes in nails?	_____ NO	_____ YES	_____ NO	_____ YES
15. Changes in hair (e.g. - dryness)?	_____ NO	_____ YES	_____ NO	_____ YES
Head:				
16. Frequent headaches?	_____ NO	_____ YES	_____ NO	_____ YES
Eyes:				
17. Any eye pain? (discomfort)	_____ NO	_____ YES	_____ NO	_____ YES
18. Any double vision?	_____ NO	_____ YES	_____ NO	_____ YES
19. Any blurred vision?	_____ NO	_____ YES	_____ NO	_____ YES
Ears, Nose & Throat:				
20. Any ringing in the ears?	_____ NO	_____ YES	_____ NO	_____ YES
21. Any ear pain?	_____ NO	_____ YES	_____ NO	_____ YES
22. Any nasal discharge?	_____ NO	_____ YES	_____ NO	_____ YES
23. Any nasal bleeding?	_____ NO	_____ YES	_____ NO	_____ YES
24. Any sinus pain?	_____ NO	_____ YES	_____ NO	_____ YES
25. Any soreness?	_____ NO	_____ YES	_____ NO	_____ YES
26. Any hoarseness?	_____ NO	_____ YES	_____ NO	_____ YES
27. Any difficulty swallowing?	_____ NO	_____ YES	_____ NO	_____ YES
Respiratory:				
28. Any chest pain?	_____ NO	_____ YES	_____ NO	_____ YES
29. Wheezing?	_____ NO	_____ YES	_____ NO	_____ YES
30. Coughing?	_____ NO	_____ YES	_____ NO	_____ YES
31. Do you or have you had tuberculosis?	_____ NO	_____ YES	_____ NO	_____ YES
32. Are you a smoker?	_____ NO	_____ YES	_____ NO	_____ YES

OVER

IN THE PAST 6 MONTHS:

HAVE YOU HAD? ARE YOU BEING TREATED BY A DR. FOR?

Neurological:

- 33. Have you had any fainting or blackouts? NO YES NO YES
- 34. History of seizures? NO YES NO YES
- 35. Any memory loss? NO YES NO YES
- 36. Numbness? NO YES NO YES
- 37A. Tingling? NO YES NO YES
- 37B. Loss of bowel control? NO YES NO YES
- 37C. Loss of bladder control? NO YES NO YES

Cardiovascular:

- 38. History of heart problems? NO YES NO YES
- 39. High blood pressure? NO YES NO YES
- 40. Low blood pressure? NO YES NO YES
- 41. Any chest pains or palpitations? NO YES NO YES
- 42. Shortness of breath with normal activities? NO YES NO YES

Gastrointestinal:

- 43. Abdominal pain? NO YES NO YES
- 44. Frequent diarrhea? NO YES NO YES
- 45. Constipation? NO YES NO YES
- 46. Heart burn? NO YES NO YES
- 47. Unexplained nausea or vomiting? NO YES NO YES
- 48. History of hepatitis? NO YES NO YES
- 49. Ulcers? NO YES NO YES

Urinary:

- 50. Frequent urination? NO YES NO YES
- 51. Painful urination? NO YES NO YES
- 52. Urinary infections? NO YES NO YES

Endocrine:

- 53. History of thyroid problems? NO YES NO YES
- 54. Heat intolerance? NO YES NO YES
- 55. Cold intolerance? NO YES NO YES
- 56. Excessive sweating? NO YES NO YES
- 57. Recent increased thirst? NO YES NO YES
- 58. Recent increased appetite? NO YES NO YES

FOR MEN ONLY

- 59. Do you have a history of prostate problems? NO YES NO YES

FOR WOMEN ONLY

- 60. Personal history of breast disease? NO YES NO YES
- 61. A family history of breast cancer? NO YES NO YES
- 62. Have you ever been pregnant? NO YES NO YES
- 63. If YES, how many times? NO YES NO YES
- 64. Personal history of ovarian cancer? NO YES NO YES

SPECIAL NEEDS (check all that apply) None

Religious Cultural Emotional Communication Physical Medical

Specify _____

Patient Signature _____

Date _____



Coordinated Health

MEDICAL HISTORY/MEDICATION FORM

Patient Name _____ DOB _____

Family Physician _____ Occupation _____

Employer _____ Length of Service _____

PAST MEDICAL HISTORY

History of:	Details	History of:	Details
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Thyroid	_____
<input type="checkbox"/> High Cholesterol	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Gastrointestinal	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Musculoskeletal	_____	<input type="checkbox"/> Other	_____

SURGICAL HISTORY

Type of Surgery:	Details	Type of Surgery:	Details
<input type="checkbox"/> Cardiac	_____	<input type="checkbox"/> Hernia	_____
<input type="checkbox"/> Gall Bladder	_____	<input type="checkbox"/> GYN	_____
<input type="checkbox"/> Appendix	_____	<input type="checkbox"/> Breast	_____
<input type="checkbox"/> Musculoskeletal	_____	<input type="checkbox"/> Hysterectomy	_____
<input type="checkbox"/> Tonsils	_____	<input type="checkbox"/> Other	_____

FAMILY HISTORY

Family History of:	Details	Family History of:	Details
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Diabetes/Renal	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Other	_____

SOCIAL HISTORY

Do you smoke? No Yes _____ packs per day Do you drink alcohol? No Yes _____ drinks per day

ALLERGIES (medications, metals, x-ray dyes or other substances): No Yes (If yes, please list names of allergen and type of reaction.)

Have you ever experienced a reaction to anesthesia? No Yes If yes, explain _____

PRESENT MEDICATIONS (List any supplements/medications you are taking to include aspirin, vitamins, laxatives, calcium, etc.)

Name of medication/supplement/vitamin, etc.	Dose (include strength and # of pills per day)	How long have you been taking this?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Patient Information Form

Race:	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Declined <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Not Reported <input type="checkbox"/> Unknown <input type="checkbox"/> White																																																									
Ethnicity:	<input type="checkbox"/> Declined <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Not Reported <input type="checkbox"/> Unknown																																																									
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Patient Signature



IMPORTANT PATIENT POLICIES

A. FINANCIAL POLICY AND ASSIGNMENT

While the filing of your insurance claims is a courtesy that we extend to our patients, we must emphasize that our relationship is with the undersigned and not with your insurance company. Because you have the relationship with your insurance company, if you are uncertain as to whether your insurance company will cover services rendered and/or supplies provided by CH, then you should contact your insurance company prior to incurring the expenses for such supplies and/or services.

Unless otherwise agreed by CH, payment for services is due at the time the services are rendered and/or supplies are provided. Some insurance companies may require referrals for services. It is your responsibility to obtain the referral prior to the time of service. If a referral is not presented before the service, the undersigned will be legally responsible for payment.

The undersigned hereby agrees to assign to CH all payments and benefits to which the below identified patient may be entitled for services rendered and/or supplies provided by CH and to be legally responsible to reimburse CH within thirty (30) days after receipt of a bill from CH for any amount that is not covered by the insurance companies, health maintenance or preferred provider organizations and/or other third parties that have been identified as being responsible for payment of the services rendered and/or supplies provided by CH to the below identified patient. Any bill from CH that is not paid by the undersigned within 90 days past shall be sent to collections. In that event, the undersigned will be legally responsible to reimburse CH for all reasonable collection and/or attorney fees and/or costs incurred by CH.

Patient's Initials _____

B. AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

I hereby authorize CH Hospital of Allentown, L.L.C and CHS Professional Practice, P.C. (CH) and its physicians, physician assistants, podiatrists, chiropractors, physical therapists and/or other employees and/or agents to furnish and/or to receive any & all information relating to the medical condition, care, treatment and/or history of the below identified patient to and/or from the following: all insurance companies, health maintenance or preferred provider organizations and/or other third parties that may be responsible for payment of the services rendered and/or supplies provided by CH; other health care providers and/or pharmacies of the below identified patient; any third party payors that are or have been responsible for pharmacy benefits of the below identified patient; and/or to all employers and/or schools of the below identified patient.

Patient's Initials _____

C. NO GUARANTEE OF CURE OR OUTCOME

I understand that no guarantee of a cure or an outcome of care/treatment can be or is given.

Patient's Initials _____

D. DISCLOSURE OF FINANCIAL INTEREST IN REFERRALS AND YOUR FREEDOM TO CHOOSE ALTERNATE PROVIDER

WE ARE REQUIRED TO NOTIFY YOU THAT CH AND/OR ITS PHYSICIANS AND/OR ITS OTHER HEALTH CARE PROVIDERS MAY REFER YOU FOR A MEDICAL SERVICE, PRODUCT OR DEVICE OR TO A FACILITY OR BUSINESS IN WHICH ONE OR MORE OF OUR PHYSICIANS HAS A FINANCIAL INTEREST. IF THAT HAPPENS, BE ADVISED THAT YOU WILL ALWAYS HAVE THE FREEDOM TO CHOOSE AN ALTERNATE PROVIDER. FURTHER, BE ADVISED THAT A LIST OF THE FACILITIES OR BUSINESSES IN WHICH ONE OR MORE OF OUR PHYSICIANS HAS A FINANCIAL INTEREST WILL BE PROVIDED TO YOU UPON YOUR REQUEST.

Patient's Initials _____

E. ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

CH has a detailed document called "Notice of Privacy Practices". It contains information about the policies and practices of CH regarding patient privacy. By signing below, the undersigned acknowledges the following about the "Notice of Privacy Practices" of CH: (a) you were offered a copy of it on the below date; and (b) you may review a copy of it on the Internet by going to www.coordinatedhealth.com and/or by requesting it at the front desk of any office of CH.

Patient's Initials _____

I HAVE REVIEWED THE ABOVE AND AGREE WITH ANY TERMS AND/OR CONDITIONS SET FORTH THEREIN.

Patient Account Number

Patient Name

Date

Signature of Patient or Legal Guardian