Family Arthritis Center/AARA Patient Registration

Name: ____ Date: ___/___/___

Referring Doctor:____________________ Primary Care Doctor: _______________________

Social Security #_____________________ Sex: Male/Female Age: ____ DOB:____/____/____

Marital Status: M S W D Race:________ Ethnicity:________ Language: English________Other________

Address:____

Number and Street Unit# City State Zip

Home Phone: ________________ Work Phone: ________________Cell Phone: ________________

Ok To Leave Message on_____Home_____Cell_____Text, Detailed- or- Brief?

Email Address: ____

Employment Status: PT FT Not Employed Student Retired Disable

Occupation: _____________________________Employer: ________________________________

Insurance company:_______________________ Policy Holder:____________________________

Policy Holder's SS#__________________ DOS:_____________ Relation to Patient:____________

Name of Spouse: _______________________ Cell phone: _________________________________

Emergency Contact: __________________ Phone Number:______________Relation:____________

Local Pharmacy Name:__________________Phone:_________________ Location:_______________

Mail Order Pharmacy: ______________________________ Phone number: _________________

******** OFFICE POLICY AND GUIDELINES********

All questions concerning fees should be asked prior to service. I authorize my insurance company to make payment for all medical services directly to Family Arthritis Center/AARA. I agree that any balances will be paid by me. I also agree that if I do not pay my balance and my account goes to a Collection

Agency that I will be responsible for all collection fees and will be charged an additional 1.5% interest per month on my collection balance until the balance is paid in full.

Transfer of medical information: I authorize Family Arthritis Center/AARA to release any information necessary to secure payment for all services provided, or to further my medical care. I authorize Family Arthritis Center/AARA to view/receive patient's medical records, including but not limited to any medical history.

It is your responsibility to have your referral with you at the time of your visit. Reminders to bring your referral are a **COURTESY**: Therefore, you must know if a referral is required. If you are unsure you need to check with our office **PRIOR** to your appointment.

Please notify the office of any changes to your address and phone number. If your insurance has changed, you need to notify the office prior to your appointment otherwise you will be responsible for the full payment of the visit. Just as a friendly reminder, we bill your insurance company as a courtesy.

The office reserves your appointment time especially for you. 24-hour notice of rescheduling or cancellation is REQUIRED. We reserve the right to charge you for a **NO SHOW** or **CANCELLED** appointment the same day of the visit. This charge will be $50 for a follow-up appointment, DEXA, Injection, or Infusion; and $100 for a New Patient appointment. We are aware that emergencies can arise, but repeated cancellations and no shows will result in **DISMISSAL** from the practice. Confirmations are a **COURTESY**; therefore, you are expected to remember your appointments.

Reciept of Office Policy/Guidelines and Privacy Practices

I ____, have received a copy of Family Arthritis Center AARA's notice of privacy practices.

Thank You,

Family Arthritis Center/AARA

_______________________________ _______________________________

Patient's Signature Date

PATIENT HISTORY FORM Name: ______________________ Date: ___/___/___

PLEASE STATE THE MAIN REASON FOR YOUR VISIT: ______________________________

____

____

MEDICAL HISTORY: Please check all the conditions that YOU have had

__ hypertension	__ diabetes	__ osteoarthritis
__ osteoporosis	__ rheumatoid arthritis	__ lupus
__ scleroderma	__ gout	__ fibromyalgia
__ heart attack	__ heart failure	__ rheumatic fever
__ mitral valve prolapse	__ high cholesterol	__ asthma
__ pneumonia	__ bronchitis	__ emphysema
__ tuberculosis	__ peptic ulcer	__ esophageal reflux
__ Chron's disease	__ ulcerative colitis	__ irritable bowel
__ hepatitis	__ anemia	__ blood transfusion
__ thyroid disease	__ kidney failure	__ kidney stones
__ psoriasis	__ epileptic seizures	__ stroke
__ depression	__ syphilis	__ gonorrhea

__ cancer (please specify): ______________________________

__ fractures and other accidents (please specify): ______________________________

__ other (please specify): ______________________________

ORTHOPEDIC SURGERY HISTORY: please list the procedures and your age at the time of surgery:

1.______________ 2. ______________ 3. ______________ 4. ______________

5.______________ 6. ______________ 7. ______________ 8. ______________

GENERAL SURGERY HISTORY: Please list the procedures and your age at the time of surgery:

1.______________ 2. ______________ 3. ______________ 4. ______________

5.______________ 6. ______________ 7. ______________ 8. ______________

MEDICATIONS: List the medications, vitamins, minerals and calcium supplements you are taking and dosage

1.______________ 2. ______________ 3. ______________ 4. ______________

5.______________ 6. ______________ 7. ______________ 8. ______________

MEDICATION ALLERGIES: List any medications you are allergic to and the symptoms you had.

1.______________ 2. ______________ 3. ______________ 4. ______________

5.______________ 6. ______________ 7. ______________ 8. ______________

PERSONAL/SOCIAL HISTORY: Marital status: ________ Children: __________ Work: ____________

Tobacco use: _____ None _______ Smoke ___ packs per day for ___ years. ____ Quit _____ When _______

Alcohol use: ____ None ____ Socially ____1-2 drinks daily ____ 3 or more drinks daily

Recreational drugs: ____ None ____ Marijuana ____ Other

Exercise: ___ Do not exercise ____ Exercise ___ times per week, specify type: ______________________

FAMILY HISTORY: List any family history that you are aware of in the spaces below:

Mother: Living age ___ Problems: ______________ Deceased age: ____ Cause: ______________

Father: Living age ___ Problems: ______________ Deceased age: ____ Cause: ______________

Sisters and Brothers: Number: ____ Serious illness or cause of death ______________________

Children: Number: ____ Serious illness or cause of death ______________________

PATIENT HISTORY page 2 NAME: ______________________ DOB: __________

REVIEW OF SYSTEMS: Check the problems you are experiencing. If no problems exist, check NONE

GENERAL __ None __ fever __ weight loss __ weight gain
__ chills __ night sweats __ fatigue __ poor sleep

SKIN __ NONE __ rash __ itching __ photosensitivity
__ open wounds/sores __ nodules __ hair loss __ insect bites

EYES __ NONE __ visual loss __ dry eyes __ red eyes

EARS __ NONE __ hearing loss __ ear pain __ ringing in ears

NOSE __ NONE __ sinus pain __ runny nose __ nosebleeds

THROAT __ NONE __ sore throat __ cough __ difficulty swallowing

MOUTH __ NONE __ dry mouth __ sores in mouth __ tooth loss

CARDIOVASCULAR __ NONE __ chest pain __ palpitations
__ abnormal valve __ abnormal beat __ poor circulation __ leg swelling

RESPIRATORY __ NONE __ shortness of breath __ cough
__ pneumonia __ bronchitis __ sputum production __ asthma

GASTROINTESTINAL __ NONE __ abdominal pain __nausea
__ heartburn __ vomiting __ constipation __ diarrhea
__ loss of appetite __ jaundice __ gallstones __ black tarry stools

ENDOCRINE __ NONE __ high blood sugar __ increased appetite
__ heat tolerance __ cold intolerance __ increased thirst __ frequent urination
__ menopausal symptoms

GENITOURINARY __ NONE __ painful urination __ difficult urination
__ blood in urine __ kidney stones __ recurrent infection __ irregular periods
__ heavy periods __ possible pregnancy __ renal failure/insufficiency

HEMATOLOGIC/LYMPHATIC __ NONE __ anemia
__ low white cells/platelets __ swollen glands __ easy bruising __ recurrent bleeding

ALLERGIC/IMMUNOLOGIC __ NONE __ frequent infection __ allergies

NEURO/PHYCH __ NONE __ headache __ muscle weakness
__ seizures __ fainting spells __ dizziness __ numbness/tingling
__ memory loss __ poor concentration __ anxiety __ depression

MUSCULOSKELETAL __ NONE __ neck pain __ back pain
__ trouble walking __ bone fractures __ accident trauma __ muscle cramps
__morning stiffness __ joint pain and swelling (list joints involved): ______________________

____

____

PLEASE USE THE SPACE BELOW TO PROVIDE ANY ADDITIONAL INFORMATION: __________

____

____

PROVIDER SIGNATURE PATIENT SIGNATURE DATE

Health Assessment Questionnaire

STANFORD UNIVERSITY SCHOOL OF MEDICINE, DIVISION OF IMMUNOLOGY AND RHEUMATOLOGY

Name____Date__________

This questionnaire is designed to help us assess how your illness affects your ability to function in daily life. Please feel free to add any additional comments on the back of this page.

Please mark "x" in the response that best describes your usual abilities OVER THE PAST WEEK:

	Without ANY difficulty (0)	With SOME difficulty (1)	With MUCH difficulty (2)	Unable to do (3)
DRESSING AND GROOMING				
Are you able to: –Dress yourself, including tying shoelaces and doing buttons?	○	○	○	○
–Shampoo your hair?	○	○	○	○
ARISING				
Are you able to: –Stand up from a straight chair?	○	○	○	○
–Get in and out of bed?	○	○	○	○
EATING				
Are you able to: –Cut your meat?	○	○	○	○
–Lift a full cup or glass to your mouth?	○	○	○	○
–Open a new milk carton?	○	○	○	○
WALKING				
Are you able to: –Walk outdoors on flat ground?	○	○	○	○
–Climb up five steps?	○	○	○	○

Please mark "x" in any AIDS or DEVICES that you usually use for any of these activities:

- ○ Cane
- ○ Walker
- ○ Crutches
- ○ Wheelchair
- ○ Devices used for dressing (button hook, zipper pull, long shoe horn, etc.)
- ○ Built-up or special utensils
- ○ Special or built-up chair
- ○ Other (Specify): ____________

Please mark "x" in any categories for which you usually need HELP FROM ANOTHER PERSON:

○ Dressing and grooming ○ Arising ○ Eating ○ Walking

Continued on other side

Please mark "x" in the response that best describes your usual abilities OVER THE PAST WEEK:

	Without ANY difficulty (0)	With SOME difficulty (1)	With MUCH difficulty (2)	Unable to do (3)
HYGIENE				
Are you able to: –Wash and dry your body?	O	O	O	O
–Take a tub bath?	O	O	O	O
–Get on and off the toilet?	O	O	O	O
REACH				
Are you able to: –Reach and get down a 5-pound object (such as a bag of sugar) from just above your head?	O	O	O	O
–Bend down to pick up clothing from the floor?	O	O	O	O
GRIP				
Are you able to: –Open car doors?	O	O	O	O
–Open jars which have been previously opened?	O	O	O	O
–Turn faucets on and off?	O	O	O	O
ACTIVITIES				
Are you able to: –Run errands and shop?	O	O	O	O
–Get in and out of a car?	O	O	O	O
–Do chores such as vacuuming or yardwork?	O	O	O	O

Please mark "x" in any AIDS OR DEVICES that you usually use for any of these activities:

- O Raised toilet seat
- O Bathtub seat
- O Jar opener (for jars previously opened)
- O Bathtub bar
- O Long-handled appliances for reach
- O Long-handled appliances in bathroom
- O Other (Specify): ____________

Please mark "x" in any categories for which you usually need HELP FROM ANOTHER PERSON:

O Hygiene O Reach O Gripping and opening things O Errands and chores

We are also interested in learning whether or not you are affected by pain because of your illness.

How much pain have you had because of your illness IN THE PAST WEEK:

NO PAIN 0 |————————————————| **SEVERE PAIN** 100

PLACE A VERTICAL (|) MARK ON THE LINE TO INDICATE THE SEVERITY OF THE PAIN

FAMILY ARTHRITIS CENTER/AARA

NOTICE OF PRESCRIPTION POLICY CHANGE:

For your convenience, we will only be giving written prescriptions for all controlled medications. This will prevent patients need to wait for refills and repeated calls to the office. Please be sure to ask your provider for any prescription refills or changes to medications in the exam room, during your office visit. It is your responsibility to know which medications you are out of and/or need refills of. Any prescriptions which are not received during your visit will need to be picked up from our office in person and taken to your pharmacy.

Lost, misplaced, or stolen narcotic prescriptions will not be replaced under any circumstances as per our office policy.

Patient Signature:____

Patient Name (Please Print):________________________________

Date:____

Witness Signature:_________________________Date:____________