Mid-America Rheumatology Consultants, PA

Patient Information

Last Name: _____

First Name, MI: _____

Street Address: _____

City, State, Zip Code: _____

Home #: _____

Cell #: _____

Employer: _____

Work #: _____

Social Security #: _____

Birth Date: _____

Sex: Male _____ Female _____

Marital Status: S P M D W

Referring Doctor: _____

Primary Care Doctor: _____

Primary Care Doctor Address: _____

Emergency Contact: _____

	Primary Insurance	Secondary Insurance
Insurance Company Name		
Insured's Name		
Insured's Birth Date		
Insured's Social Security Number		
Relationship to Patient		
Policy/ID Number		
Group/Employer Number		
Claims Mailing Address		
City, State, Zip		

Account Number: _____

MEDICARE INSURANCE ACKNOWLEDGEMENT

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration, or intermediaries or carriers of any information needed for any Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Mid-America Rheumatology Consultants, P.A.

I believe the insurance information that I have provided Mid-America Rheumatology Consultants, P.A. is correct.

I understand it is my responsibility to inform Mid-America Rheumatology Consultants, P.A. of any insurance changes.

If the insurance information listed below is incorrect, I understand I will be held responsible for the charges incurred and not reimbursed as a result of this information.

Name (Please Print) _____.

Primary Insurance Company: _____.

Secondary Insurance Company: _____.

Date: _____ Signature: _____

MEDIGAP LIFETIME CONSENT

I request payment of authorized Medigap benefits be made either to me or on my behalf to Mid-America Rheumatology Consultants, P.A. for any service furnished to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

Date: _____ Signature: _____

Account # _____

INSURANCE ACKNOWLEDGEMENT

I authorize Mid-America Rheumatology Consultants, P.A. to release information about my care and treatment to my insurance company for the purpose of filing my insurance claims. I authorize payment of benefits to be made directly to Mid-America Rheumatology Consultants, P.A.

I believe the insurance information that I have provided Mid-America Rheumatology Consultants, P.A. is correct.

I understand it is my responsibility to inform Mid-America Rheumatology Consultants, P.A. of any insurance changes.

If the insurance information listed below is incorrect, I understand I will be held responsible for the charges incurred and not reimbursed as a result of this information.

Name (Please Print) _____.

Primary Insurance Company: _____.

Secondary Insurance Company: _____.

Date: _____ Signature: _____

Account # _____

Mid-America Rheumatology Consultants Patient Pharmacy Form

In order for us to fill your prescriptions electronically please fill out **ALL** information.

Name: _____ D.O.B.: _____

Date: _____

#1 Pharmacy Information:

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

#2 Pharmacy Information:

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

#3 Pharmacy Information:

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Mid-America Rheumatology Consultants, PA
NEW PATIENT HISTORY

Name _____ Date of Birth _____/_____/_____ Age _____

Referring Physician _____ Primary Care Physician _____
Orthopedic Physician_____ Other specialists seen for this problem_____
_____

Reason for Appointment (Problem that led to Rheumatology referral): _____
_____
When did symptoms begin (approximately): _____
Has there been a diagnosis given? _____
Place a mark on the line below to rate your average pain level:
No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Severe Pain
List previous treatment for this problem (medications, injections, therapy, surgery,etc):
_____
List X-Rays, CT, MRI, or other tests done for this problem? _____
_____

Past Medical History
Rheumatology/Arthritis history:

___Arthritis (unknown type)	___Gout	___Lupus (SLE)
___Osteoarthritis	___Ankylosing Spondylitis	___Bursitis/Tendinitis
___Rheumatoid arthritis	___Back Pain	___Osteoporosis/Osteopenia
___Psoriatic arthritis	___Polymyalgia Rheumatica	___Vasculitis
___Childhood arthritis (JRA/JIA)	___Giant Cell Arteritis/Temporal Arteritis	

___Anemia	___Glaucoma	___Jaundice
___Asthma	___Heartburn/GERD	___Kidney Disease
___Blood Clots	___Heart problems	___Kidney Stones
___Cancer	___Hepatitis	___Pneumonia
___Cataracts	___High blood pressure	___Psoriasis
___Colitis	___HIV/AIDS	___Seizures
___Diabetes	___Iritis/Uveitis	___Rheumatic Fever
___Fibromyalgia	___Stomach Ulcer	___Tuberculosis
___Thyroid disease	___Stroke / CVA / TIA	___Depression/Anxiety

Others: _____
Major Injuries / Fractures: _____

Past Surgical History

Date	Procedure
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

*Attach list if additional _____

Mid-America Rheumatology Consultants, PA
NEW PATIENT HISTORY

Family History

	Health is: Good/ Stable/ Poor	Deceased	Age(s)	Medical Problems
Mother				
Father				
Sister(s)				
Brother(s)				
Daughter(s)				
Son(s)				
Others				

If not listed above, check if family history of:
Arthritis (circle one): ___Osteoarthritis (age/injury related) ___Rheumatoid Arthritis
___Hypertension __Diabetes __Cancer __Fibromyalgia __Gout __Heart disease
___Lupus __Ulcer disease ___Psoriasis __Tuberculosis __Stroke __Kidney disease
___Thyroid disease ___Depression ___Anxiety Other: _____

Social History

Most recent occupation: _____ Hours worked/week: _____ Employer:_____
Check one: ___Married/Domestic Partner ___Widowed ___Single _____Divorced
Health of spouse/partner _____Age ____

	Type used	How often? (daily, weekly, etc)	How many? (Ex. 1 cigarette, 1 beer/drink, etc)	How many years?
Tobacco				
Alcohol				
Other illicit substance use/abuse				

Allergies

____None
Medication_____ Reaction_____
Medication_____ Reaction_____
Medication_____ Reaction_____
Medication_____ Reaction_____
Medication_____ Reaction_____
Other allergies:_____
*Attach list if additional allergies_____

Mid-America Rheumatology Consultants, PA
NEW PATIENT HISTORY

Current Medications (including over-the-counter medications, vitamins, supplements, etc)

Medication Name	Strength (mg, etc)	Dose (how many pills, etc)	Frequency (times per day/wk/mo)

*Attach list if additional_____

Are you taking any other medications not listed above for the condition you were referred here?

_____

Other Diagnostic Tests (if applicable)

	Date	Result, if known:
Hand X-Rays	____/____/____	_____
Feet X-Rays	____/____/____	_____
Chest X-Ray	____/____/____	_____
DEXA (Bone Density)	____/____/____	_____
TB Skin Test (or Quantiferon TB blood test)	____/____/____	_____
Colonoscopy	____/____/____	_____

Females Only – Pregnancy History

# of pregnancies _____ # of successful deliveries _____ # of miscarriages _____

Pregnancy complications: _____

_____

Mid-America Rheumatology Consultants, P.A.

Name:_____ Date of Birth: _____/_____/_____

REVIEW OF SYSTEMS

(If present, check below)

GENERAL
__Fatigue
__Fever
__Weight loss
__Weight gain
__Insomnia
__Increased susceptibility to infection

SKIN
__Rash
__Hives
__Sun sensitive (sun allergy)
__Nodules/Bumps
__Skin tightness
__Hair loss
__***Color*** change of hands or feet in the cold

HEAD/EYES/EARS/ NOSE/MOUTH
__Eye Pain
__Eye Redness
__Dry Eyes
__Change in vision
__Ringing in the ears
__Hearing loss
__Nose bleed
__Dry mouth
__Oral ulcers
__Decreased taste
__Hoarseness
__Difficulty swallowing
__Sneezing

RESPIRATORY (LUNGS)
__Shortness of breath
__Difficulty breathing on exertion
__Cough
__Wheezing

CARDIOVASCULAR
__Chest pain
__Irregular heart beat
__Leg swelling (edema)
__Abnormal blood pressure

GASTROINTESTINAL
__Nausea
__Vomiting
__Abdominal pain
__Heartburn / GERD
__Diarrhea
__Constipation
__Bloody stool
__Black/tarry stool
__Jaundice

GENITOURINARY
__Pain/burning on urination
__Discolored urine
__Vaginal discharge
__Vaginal dryness
__Last menstrual period: ____/____/____
__Penile discharge
__Prostate trouble

MUSCULOSKELETAL
__Back pain
__Joint pain
__Joint stiffness
__Joint swelling
__Muscle pain
__Muscle weakness

NEUROLOGICAL
__Headaches
__Dizziness
__Loss of consciousness
__Memory loss
__Numbness or tingling

PSYCHIATRIC
__Depression
__Anxiety
__Panic attacks
__Agitation
__Easily losing temper

ENDOCRINE
__Excessive thirst
__Excessive urination
__Cold intolerance
__Heat intolerance

HEMATOLOGY
__Easy bruising
__Swollen/tender glands
__History of transfusion