Name: \_\_\_\_\_     \_\_\_\_\_ Date of Birth: \_\_\_\_     \_\_\_

Referred by:\_\_\_     \_\_\_ Diagnosis you were given: \_\_\_\_     \_\_\_\_

**List Priority of Problems based on severity for you TODAY:**

1. \_\_\_\_     \_\_\_\_\_
2. \_\_\_\_     \_\_\_\_\_
3. \_\_\_\_     \_\_\_\_\_

Date problem started (be as accurate as possible): \_\_\_     \_\_\_

How is the problem changing?

( [ ]  ) Worse rapidly ( [ ]  ) Worse slowly ( [ ]  ) Slowly better ( [ ]  ) Not changing

When are symptoms most severe? ( [ ]  ) Morning ( [ ]  ) Late Afternoon ( [ ]  ) Night

How severe is your pain this week? \_     \_ How severe is your fatigue this week? \_\_     \_\_

 (On a scale of 0-10: “0” is no complaints, “10” is extremely severe)

How long are you stiff when you get out bed in the morning (in hours/minutes)? \_\_\_     \_\_\_\_

Do you have any of the following:

( [ ]  ) Weight loss… how much \_\_\_\_ lbs. ( [ ]  ) Blue fingers or toes ( [ ]  ) Eye Pain

( [ ]  ) Weight gain… how much \_\_\_\_ lbs. ( [ ]  ) Coughing or Wheezing ( [ ]  ) Vomiting

( [ ]  ) Fever > 101.0 ( [ ]  ) Dry mouth or Dry eyes ( [ ]  ) Stomach pain

( [ ]  ) Weakness in one arm or leg ( [ ]  ) Mouth sores ( [ ]  ) Diarrhea

( [ ]  ) Numbness in hand or foot ( [ ]  ) Rash ( [ ]  ) Depression

( [ ]  ) Fatigue ( [ ]  ) Headaches ( [ ]  ) Insomnia

Medication Allergies:\_\_\_\_\_\_     \_\_\_\_\_\_\_\_

Medications tried but not effective… or not tolerated: \_\_\_\_     \_\_\_\_\_

What medication has helped the most? \_\_\_\_     \_\_\_\_\_\_

Current Prescription Medications (and doses)

\_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_

\_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_

\_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_

\_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_ \_\_\_     \_\_\_

Operations of procedures (include dates): \_\_\_\_\_     \_\_\_\_

Other Hospitalizations (pneumonia/infection, childbirth, blood clots, etc.) include dates:

\_\_\_\_\_     \_\_\_\_\_\_

Medical problems not listed above (diabetes, hypertension, thyroid, cancer, osteoporosis, etc.):

\_\_\_\_     \_\_\_\_\_\_\_

Blood Transfusion? ( [ ]  ) Date: \_     \_ TB test positive? \_     \_ Last TB skin test? \_     \_

Chronic or Recurring Infections (hepatitis, shingles, sinusitis, bronchitis, fungus/yeast):

\_\_\_\_     \_\_\_\_\_

Childhood Illnesses: ( [ ]  ) Chickenpox ( [ ]  ) Mumps ( [ ]  ) Rheumatic fever ( [ ]  ) Measles

Family History: (List family members affected)

Osteoarthritis: \_\_\_\_\_     \_\_\_\_\_\_

Rheumatoid Arthritis: \_\_\_\_\_\_     \_\_\_\_\_\_

Systemic Lupus: \_\_\_     \_\_\_\_

Other Autoimmune Disease: \_\_     \_\_\_

Cancer: \_\_\_     \_\_\_\_

Heart Disease: \_\_\_     \_\_\_

Tuberculosis, Hepatitis, other infection: \_\_\_     \_\_\_

Blood clotting problems: \_\_\_     \_\_\_\_

Social History:

([ ] ) Married ([ ] ) Divorced ([ ] ) Single ([ ] ) Widow/Widower

( [ ]  ) Children (ages): \_\_\_     \_\_\_\_\_\_\_\_\_\_

( [ ]  ) Smoker (packs/day): \_\_     \_\_\_\_ ( [ ]  )Alcohol (per week): \_\_\_     \_\_\_\_\_

( [ ]  ) History of IV drug use ([ ] ) History of narcotic dependence

( [ ]  ) Employed (> 20 hrs/wk) Job title: \_\_\_\_\_     \_\_\_\_\_

 Major physical activity of job (sit, stand, walk, up/down): \_\_     \_\_\_\_

 Repetitive tasks at work (typing, lifting, writing, phone): \_\_\_\_     \_\_\_\_\_

( [ ]  ) Not employed

( [ ]  ) Student

( [ ]  ) Retired … from what job: \_\_\_\_     \_\_\_\_\_

( [ ]  ) On Disability … from what job: \_\_\_\_     \_\_\_\_

( [ ]  ) Pets or animal exposure? What kind: \_\_\_     \_\_\_\_

Favorite leisure activity (gardening, golf, reading, walking, etc): \_\_\_     \_\_\_

Years of formal Education (high school = 12, college = 16, etc.) \_\_     \_\_\_

Diploma from: \_\_\_     \_\_\_\_

|  |
| --- |
|  |
| **NEW PATIENT REGISTERATION FORM** |

|  |
| --- |
| PATIENT INFORMATION |
| Patient’s last name: | First name: | Middle name: |
|       |       |       |
| Mailing address: | City: | State: | ZIP code: |
|       |       |       |       |
| Home phone no.: | Cell phone no.: | Work phone no.: |
|  (       )       -       |  (       )       -       |  (       )       -       |
| Patient Date of Birth: | Patient Age: | Patient Sex: | Marital Status: |
|        /       /       |       |  [ ]  M | [ ]  F |  [ ]  single  | [ ]  married  | [ ]  divorced  | [ ]  widowed  | [ ]  other |
| Social Security no.: | Ethnicity: Race: Language:  |
|        -       -       |                   |
| Employment Status: Employer Name:  |
|  [ ]  full time |  [ ]  part time | [ ]  not employed | [ ]  retired       |
| Who may we discuss your medical history with:  |
|       |

|  |
| --- |
| IN CASE OF EMERGENCY |
| Name of emergency contact person: | Relationship to patient: | Home phone no.: | Work phone no.: |
|       |       | (       )      -       | (     )      -       |
| Mailing address: | City: | State: | ZIP code: |
|       |       |       |       |

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| RESPONSIBLE PARTY (Guarantor) Check if self [ ]  |
| The guarantor is the person responsible for the patient’s bill. If the patient is responsible for his/her own bill, please skip the next section. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient. |
| Guarantor’s last name: | Guarantor’s first name: | Guarantor’s middle name: |
|       |       |       |
| Guarantor’s mailing address, if different from patient: | City: | State: | ZIP code: |
|       |       |       |       |
| Guarantor’s phone number: | Relationship to patient: | Guarantor’s date of birth: | Guarantor’s Social Security No.: |
| (       )       -       |       |        /       /       |        -       -       |

|  |
| --- |
| INSURANCE INFORMATION |
| Name of primary insurance: | Policy subscriber’s name, if not patient: | Policy subscriber’s date of birth: |
|       |       |        /       /       |
| Patient’s relationship to subscriber: | [ ]  Self | [ ]  Spouse | [ ]  Child | [ ]  Other, please specify:      |
| Name of secondary insurance (if applicable): | Policy subscriber’s name, if not patient: | Policy subscriber’s date of birth: |
|       |       |        /       /       |
| Patient’s relationship to subscriber: | [ ]  Self | [ ]  Spouse | [ ]  Child | [ ]  Other, please specify:      |

|  |
| --- |
| OTHER INFORMATION |
| Pharmacy name: | Pharmacy location: | Pharmacy phone no: |
|       |       | (       )       -       |
| How did you hear about our office? Referred by? | Email:  |
|         |       |

**Tennessee Rheumatology**

**Financial Policy, Assignment Information, and Release of Information**

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance or Medicare benefits to be paid directly to Tennessee Rheumatology or its assignees. I am responsible for any non-covered services, supplies, co-payments or deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. This acceptance and assignment will be in force for all future services by practitioners from this office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_     \_\_\_\_

Signature of Patient or Patient’s guardian/representative Date

\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of person signing above

**Acknowledgement of Notice of Privacy Practices**

I understand that as part of my health care, Tennessee Rheumatology originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

* A basis for planning my care and treatment,
* A means of communication among the many health professionals who contribute to my care,
* A source of information for applying my diagnosis and surgical information to my bill,
* A means by which a third-party payer can verify that services billed were actually provided, and
* A tool for routine healthcare operations such as assessing quality.

I understand that Tennessee Rheumatology maintains a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. The most recent version of this Notice is displayed in the waiting room area. I understand that Tennessee Rheumatology reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional written copy of this Notice at any time. I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent, and
* The right to request restrictions as to how my health information may be used or disclosed.

I have had an opportunity to receive and review the *Notice of Privacy Practices* of Tennessee Rheumatology.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_     \_\_\_\_\_\_

Signature of Patient or Patient’s guardian/representative Date

\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of person signing above