Arthritis Care of Texas

NEW PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss	Ethnicity: ☐ Hispanic ☐ Non-Hispanic	Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: M F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by (please circle): Doctor Family Member Friend Insurance Plan

INSURANCE INFORMATION

(Please present your insurance card to every visit)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ____Yes ____ No

Please indicate primary insurance ___BCBS ___United Health Care ___Aetna ___Humana ___Cigna ___Christus Health ___WellMed ___Medicare ___Other _____

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Authorization to Treat: I consent to examination, treatment and procedures which may be performed during my office visits including emergency treatment considered necessary by the physician and/or his designated provider. **Assignment of Insurance:** I hereby assign payment directly to Arthritis Care of Texas for services covered by insurance or other health benefit plans. **Authorization for Release of Information:** I authorize Arthritis and Osteoporosis Center of Coastal Bend to release to my insurance carrier and its designated agents any medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS, necessary to process any healthcare related review or quality assurance activities. I also authorize the release of medical information to other healthcare providers who provide consultative services regarding my healthcare. This authorization remains in effect until revoked by me in writing. I agree that a photocopy of the same is as valid as the original. **Acknowledgement of Financial Responsibility:** I hereby acknowledge that I am fully responsible for any portion of my bill which has been allowed, but not covered by my insurance, including copays, deductible and coinsurance, and therefore, agree to pay such portion at the time of service or immediately upon receipt of a patient statement.

Patient/Guardian signature *Date*

Arthritis Care of Texas

HIPAA COMMUNICATION
AUTHORIZATIONS

Patient Contacts

I/We authorize Arthritis Care of Texas to leave messages or discuss my PHI with the names listed below: (Include name and relationship)

_____ Phone: _____

_____ Phone: _____

Primary Care Doctor _____ Phone: _____

Referring Doctor _____ Phone: _____

Other _____ Phone: _____

I authorize Arthritis Care of Texas to use the following form(s) of communication when contacting me about upcoming appointments, my medical care, my prescriptions, and/or my bill with the practice. *(check all that apply)*

☐ Voicemail home phone ☐ Voicemail personal cell phone ☐ Text personal cell phone ☐ Email

Privacy Policies and Office Policies

I agree to the Privacy Policies (HIPPA) and Office Policies of Arthritis Care of Texas. I understand that a full copy of both the Privacy Practices and Office Policies are available to me at the office and at our website www.aoccb.com.

Patient Signature: _____ Date: _____

Preferred Retail Pharmacy

Pharmacy Name	
Phone Number	
Address	
Store Number	

Arthritis Care of Texas

Medication Refill Policy

Medications prescribed by Arthritis Care of Texas physicians as indicated for each patient's health and medical conditions. **Usually enough medication or refills are given to last until your next appointment with the physician. Please be sure to keep up with your follow up appointments** to ensure your doctor can appropriately monitor your medical problems and the effectiveness of the medications you are taking.

If your medication needs to be refilled between office visits, the following protocol needs to be followed:

General information & policy:

- Bring all medications you take to every visit for your medical assistant and/or physician to review
- All medications refill requests are done **during office hours**, NO EXCEPTION. After hour, on call phone is only mean to be used for urgency need.
- Please allow up to 2 weeks for processing if your insurance requires a pre-authorization on any medication.

DMARDs- Methotrexate, Sulfasalazine, Arava (leflunamide), Plaquenil (hydroxychloroquin), Imuran (azathioprine), etc

- A onetime **1-month** medication refill can be given if the patient has not been seen for **3 months** after last visit and a subsequent follow up appointment needs to be made.
- No refill will be given if patient has not been seen for over 3 months, NO EXCEPTION.

Biologic - Humira, Enbrel, Cimzia, Orencia, Actemra, Simponi, Benlysta, etc

- A onetime **1-month** medication refill can be given if the patient has not been seen for **3 months** after last visit and a subsequent follow up appointment needs to be made.
- No refill will be given if patient has not been seen for over 3 months, NO EXCEPTION.
- Consider calling **at least 2 weeks** before you run out of your medication.

All other general medications

- A onetime **1-month** medication refill can be given if the patient has not been seen for **3-6 months after last visit** and a subsequent follow up appointment needs to be made.
- No refill will be given if patient has not been seen for **over 6 months**, NO EXCEPTION.

Patient Signature:_____ Date: _____

Arthritis Care of Texas
PATIENT MEDICAL HISTORY FORM

Name:_____ Age:_____ Date of Birth_____/_____/_____ Marital Status: _____

Date symptoms started:_____ Primary reason for visit:_____

MEDICAL HISTORY *(check all that apply)*

□ Asthma
□ Cancer *(list type)*_____
□ Colitis
□ Hepatitis
□ HIV/AIDS
□ Iritis
□ Psoriasis
□ Rheumatic Fever
□ Seizures
□ Stroke
□ Thyroid Disease
□ Tuberculosis
□ Ulcers
□ Uveitis
□ Venous Thrombosis

LIST ALL DIAGNOSED MEDICAL CONDITIONS

_____

_____

_____

_____

_____

LIST ALL PREVIOUS SURGERIES:

_____

_____

_____

_____

Preferred Pharmacy:_____
(Name, City)

SOCIAL HISTORY *(check all that apply)*

□ Alcohol use: _____ drinks per week □ No Alcohol use
□ At risk for HIV infection (unprotected sex, IV drug use, history of blood transfusions)
□ History of drug use
Smoking Status: □Current If current: _____ packs per day
□Former (when quit: _____) □Never smoked
Second hand smoke exposure:
□ Environmental □ Occupational □Perinatal/before birth
□ Tobacco use (other/chew): _____

FEMALE PATIENTS ONLY:

Number of miscarriages: _____

LIST CURRENT MEDICATIONS & SUPPLEMENTS:
(use back of this form for more space)

Name	Dose	Frequency	Route

LIST ALLERGIES TO MEDICATIONS: □ No Known Allergies

_____

_____

FAMILY HISTORY *(check if blood relatives have the following)*

DISEASE	RELATIONSHIP TO YOU
□ Ankylosing Spondylitis	_____
□ Asthma	_____
□ Blood Clots	_____
□ Cancer	_____
□ Colitis	_____
□ Diabetes	_____
□ Heart Disease	_____
□ Hypertension	_____
□ Iritis	_____
□ Liver Disease	_____
□ Lupus	_____
□ Osteoarthritis	_____
□ Osteoporosis	_____
□ Psoriasis	_____
□ Arthritis	_____
□ Reactive Arthritis	_____
□ Rheumatoid Arthritis	_____
□ Tuberculosis	_____
□ Uveitis	_____

REVIEW OF SYSTEMS
PLEASE CIRCLE 'YES' or 'NO' FOR ALL ITEMS BELOW
(Problems you have had within the past 3 months)

ALLERGY/IMMUNE
Yes No Hayfever
Yes No Swollen glands or nodes
Yes No Weak immune system

CARDIOVASCULAR
Yes No Chest pain
Yes No High blood pressure
Yes No Palpitation or heart racing
Yes No Swelling in legs or feet

EARS
Yes No Ear aches
Yes No Ear infections
Yes No Hearing problems
Yes No Tinnitus
Yes No Vertigo

ENDOCRINE
Yes No Breast discharge
Yes No Diabetes
Yes No Excessive thirst
Yes No Heat or cold intolerance
Yes No Thyroid problems

EYES
Yes No Blurry vision
Yes No Double vision
Yes No Glasses or contacts
Yes No Glaucoma

GENERAL
Yes No Fatigue
Yes No Fever
Yes No Loss of appetite
Yes No Night sweats
Yes No Recent weight change

GASTROINTESTINAL
Yes No Abdominal pain
Yes No Blood in stool
Yes No Constipation
Yes No Diarrhea
Yes No Difficulty swallowing
Yes No Heartburn
Yes No Nausea or vomiting

GENITOURINARY
Yes No Blood in urine
Yes No Frequent urination
Yes No Kidney stones
Yes No Loss of bladder control

HEMATOLOGIC/LYMPH
Yes No Anemia
Yes No Blood transfusions
Yes No Easy bruising or bleeding

INTEGUMENTARY (Skin)
Yes No Changes in hair or nails
Yes No Dryness
Yes No New stretch marks
Yes No Rashes

MOUTH and THROAT
Yes No Dry mouth
Yes No Frequent sore throats
Yes No Sore tongue

MUSCULOSKELETAL
Yes No Back pain
Yes No Muscle cramps
Yes No Muscle weakness
Yes No Neck pain
Yes No Swelling or pain in joints

NEUROLOGIC
Yes No Frequent headaches
Yes No Head injury
Yes No Loss of consciousness
Yes No Numbness around mouth
Yes No Numbness or tingling
Yes No Seizures
Yes No Tremors

NOSE and SINUSES
Yes No Frequent colds
Yes No Nasal stuffiness
Yes No Sinus troubles

PSYCHIATRIC
Yes No Anxiety
Yes No Depression

RESPIRATORY
Yes No Asthma
Yes No Frequent cough
Yes No Shortness of breath
Yes No Spitting up blood
Yes No Wheezing

I have reviewed the above and circled all symptoms which apply. _____
Signature

Patient Name:_____
Date of Birth:_____
Today's Date:_____