NEW PATIENT INFORMATION

Personal

Mr. Ms. Mrs. Miss Dr. Other ________________

Last Name ____ First Name __________________________ MI _____

Home Address ______________________________ City _________________ State _________ Zip ___________

Mail Address _______________________________ City _________________ State _________ Zip ___________

Is This a Nursing Home? ________ Facility Name ____

Telephone # __________________ Cell Phone # _________________ E-Mail ______________________________

Date of Birth __________________ Age __________ Sex ___________

Social Security # _______________

Spouse

Last Name ____ First Name __________________________ MI _____

Social Security # _______________ Date of Birth __________________

Employer ____ Telephone # __________________

Responsible Party (if other than self)

Name ____ Social Security # _______________

Relationship ____ Date of Birth _________________________

Home Address ______________________________ City _________________ State _________ Zip ___________

Home Telephone # ____________________

Employer ____ Work Telephone # _____________________

Emergency Contact

Contact Name ____ Relationship __________________

Home Address ______________________________ City _________________ State _________ Zip ___________

Telephone # __________________

Employment

Occupation ____

Employer Name ____ Telephone # __________________

Address ____________________________ City _________________ State _________ Zip ___________

Education

Currently a Student? ___________________ Where ____

Insurance Information

Primary Insurance

Company ________________________________ Group # ______________ ID # ________________

Address ____ Telephone # ________________

City ______________________________ State _________ Zip ___________ Effective Date ________________

Policy Holder ____ Relationship to Patient ________________

Secondary Insurance

Company ________________________________ Group # ______________ ID # ________________

Address ____ Telephone # ________________

City ______________________________ State _________ Zip ___________ Effective Date ________________

Policy Holder ____ Relationship to Patient ________________

Other Insurance

Company ________________________________ Group # ______________ ID # ________________

Address ____ Telephone # ________________

City ______________________________ State _________ Zip ___________ Effective Date ________________

Policy Holder ____ Relationship to Patient ________________

Medical

Date of First Appointment ________________
Referred to this office by:
Physician's Name ____City __________________________________
Telephone # ____________________
Your Pharmacy ____Telephone # ____________________

Rheumatologic (Arthritis) History

At any time, have you or a blood relative had any of the following? (check if yes)

	You	Relative	Name/Relationship
Arthritis (type unknown)			______________________________
Osteoarthritis			______________________________
Rheumatoid Arthritis			______________________________
Gout			______________________________
Lupus or "SLE"			______________________________
Ankylosing spondylitis			______________________________
Childhood arthritis			______________________________
Osteoporosis			______________________________

Past Personal History

Do you or have you had any of the following? (check if yes)

Cancer	Heart Problems	Asthma	Goiter
Leukemia	Stroke	Cataracts	Diabetes
Epilepsy	Nervous Breakdown	Stomach Ulcers	Rheumatic Fever
Bad Headaches	Jaundice	Colitis	Kidney Disease
Pneumonia	Psoriasis	Anemia	

Other Significant Illnesses: ____
____
____

Previous Operations:

	Type	Year	Surgeon / City
1)	______________________	______	______________________
2)	______________________	______	______________________
3)	______________________	______	______________________
4)	______________________	______	______________________
5)	______________________	______	______________________
6)	______________________	______	______________________
7)	______________________	______	______________________

Previous Fractures: (describe) ____
____

Serious Injuries (describe) ____
____

Family History

	If Living Age	Health	If Deceased Age	Cause
Father	______	______________________________	______	_____________________________
Mother	______	______________________________	______	_____________________________

Enter the numbers of any of the following that are applicable:

Brothers	Living _____	Deceased _____	
Sisters	Living _____	Deceased _____	
Children	Ages _______________	Living _____	Deceased _____

Serious Illnesses of Children ____

Has any blood relative had any of the following? (check if yes)

	Name/Relationship
Cancer	
Heart Disease	
Rheumatic Fever	
Tuberculosis	
Leukemia	
High Blood Pressure	
Epilepsy	
Diabetes	
Stroke	
Bleeding Tendency	
Asthma	
Goiter	
Colitis	
Alcoholism	

Marital Status

Never Married
Married
Divorced
Separated

Spouse Age: Alive ___________ Deceased _____________

Major Illnesses ____

System Review

General
_____ Recent weight gain/amount
_____ Recent weight loss/amount
Fatigue
Weakness
Fever

Nervous System
Headaches
Dizziness
Fainting
Muscle spasm
Loss of consciousness
Sensitivity or pain in hands or feet
Memory loss

Ears
Ringing in ears
Loss of hearing

Eyes
Pain
Redness
Loss of vision
Double or blurred vision
Dryness
Feels like something in eye

Nose
Nosebleeds
Loss of smell
Dryness

Mouth
Sore tongue
Bleeding gums
Sores in mouth
Loss of taste
Dryness

Throat
Frequent sore throats
Hoarseness
Difficulty in swallowing

Neck
Swollen glands
Tender glands

Heart and Lungs
Pain in chest
Irregular heartbeat
Sudden change in heartbeat
Shortness of breath
Difficulty breathing at night
Swollen legs or feet
High blood pressure
Heart murmurs
Cough
Coughing of blood
Wheezing
Night sweats

Stomach and Intestines
Nausea
Vomiting of blood or coffee ground material
Stomach pain relieved by food or milk
Yellow jaundice
Increasing constipation
Persistent diarrhea
Blood in stools
Black stools
Heartburn

Kidney/Urine/Bladder
Difficult urination
Pain or burning on urination
Blood in urine
Cloudy, “smoky” urine
Pus in urine
Discharge from penis/vagina
Frequent urination
Getting up at night to pass urine
Vaginal dryness
Rash/ulcers on genitals
Sexual difficulties
Prostate trouble

Blood
Anemia
Bleeding tendency

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

Muscles/Joints/Bones
Morning stiffness
Lasting: ____ minutes
____ hours
Joint pain
Muscle weakness
Muscle tenderness
Joint swelling
List joints affected in last 6 months
____
____
____
____
____

Habits
Drink coffee?
Cups per day _________
Smoke?
Cigarettes per day _____
Did you smoke in the past?
Cigarettes per day _____
Alcohol?

Has anyone ever told you to cut down on your drinking?
_____ Yes _____ No

Do you use drugs for reasons that are not medical? If so, please list:
____
____

How many pillows do you use to sleep on each night? ___________

Do you get enough sleep at night?
_____ Yes _____ No

Do you wake up feeling rested:
_____ Yes _____ No

Diagnostic

Date of last eye examination _______________
Date of last chest x-ray _______________
Date of last tuberculosis test _______________

Menstrual

Age when periods began __________
Periods regular? Yes No
How many days apart? _________
Date of last period ______________
Date of last pap smear ______________
Bleeding after menopause? Yes No

Medications

Drug Allergies _____ Yes _____ No
To what drugs ______________________________
Type of reaction ______________________________

Current Medications (List any medication you are taking at this time, including items such as aspirin, vitamins, laxatives, calcium supplements, etc.)

Name of Drug	Dose (Include strength and number of pills per day)	How long have you taken this medication?	Did it help? A Lot	Some	Not at all

Arthritis Medications (Please review this list of “arthritis” medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication, and any reactions you may have had)

Name of Drug	Dose (Include strength and number of pills per day)	How long have you taken this medication?	Did it help? A Lot	Some	Not at all
Aspirin	________	________			
	Reaction ________				
Aspirin-containing products	________	________			
	Reaction ________				
Benemid	________	________			
	Reaction ________				
Clinoril	________	________			
	Reaction ________				
Colchicine	________	________			
	Reaction ________				
Cortisone/Prednisone	________	________			
	Reaction ________				
Cytoxan	________	________			
	Reaction ________				
Darvon/Darvocet	________	________			
	Reaction ________				
Disalcid	________	________			
	Reaction ________				
Enbrel	________	________			
	Reaction ________				
Feldene	________	________			
	Reaction ________				
Gold - shots or pills	________	________			
	Reaction ________				
Humira	________	________			
	Reaction ________				
Imuran	________	________			
	Reaction ________				
Indocin	________	________			
	Reaction ________				
Methotrexate	________	________			
	Reaction ________				
Motrin/Ibuprofen	________	________			
	Reaction ________				
Naprosyn	________	________			
	Reaction ________				
Orencia	________	________			
	Reaction ________				
Plaquenil	________	________			
	Reaction ________				
Remicade	________	________			
	Reaction ________				
Rituxan	________	________			
	Reaction ________				
Tylenol (plain)	________	________			
	Reaction ________				
Tylenol (with codeine)	________	________			
	Reaction ________				
Zyloprim/Allopurinol	________	________			
	Reaction ________				
Other	________	________			
	Reaction ________				

PLEASE READ AND SIGN THE FOLLOWING

I hereby authorize Arthritis and Rheumatology Clinics of Kansas, LLC to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to same all payments for medical service rendered to me. A photocopy of this authorization and assignment shall be as binding as the original.

Patient Signature ____Date ______________

Parent/Guardian Signature _______________________________________Date ______________
(If patient is a minor)

MEDICARE PATIENTS ONLY

ONE TIME AUTHORIZATION

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Arthritis and Rheumatology Clinics of Kansas, LLC for any services furnished me by those physicians. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature ____Date ______________

MEDIGAP AUTHORIZATION FORM

I hereby authorize payment of my Medigap benefits to Arthritis and Rheumatology Clinics of Kansas, LLC for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Patient Signature ____Date ______________

Medicare Number ______________________

Medigap Insurer ____ID # ______________

Address ____Telephone # ______________

City ___________________________State ________Zip __________Effective Date ______________