**RHEUMATOLOGY ASSOCIATES**
of South Florida

# PATIENT INFORMATION

Date ____________________

Patient's Name ______________________________ Age ______ Sex ______ Date of Birth ________________

Patient's Social Security Number ______________________________

Local Address ______________________________________________ Apt/Unit __________

City ______________________________ State ______________ Zip Code ______________

Cell Phone Number ______________________________ Home Phone Number ______________________

Work Phone Number ______________________________ Email ______________________________

Primary Emergency Contact Person ______________ Phone # ______________________________

**IF YOU'RE A SEASONAL RESIDENT AND YOU HAVE ANOTHER ADDRESS, PLEASE FILL IN BELOW**

Away Address ______________________________________________ Apt/Unit __________

City ______________________________ State ______________ Zip Code ______________

Telephone Number ______________________________

**PLEASE CIRCLE BELOW**

**Preferred Language:** English, Spanish, French, German, Other, Refused to Report

**Race:** White, African American, American Indian or Alaskan Native, Asian, Native Hawaiian or Pacific Island, Other, Refused to Report

**Ethnicity:** Hispanic, Non-Hispanic, Refused to Report

Employed By ______________________________ Occupation ______________________________

**Marital Status** (Circle One) Single, Married, Widowed, Divorced, Separated, Partner

Spouse's Name (if applicable) ______________________________ Spouse's Date of Birth ________________

Spouse's Social Security Number (Applicable if secondary insurance in under spouses name) ________________

Referred to the Practice by ______________________ Primary Doctor ______________________

**Local Pharmacy Name, Phone # or Address and City**

1. ______________________________________________________________

2. ______________________________________________________________

**Mail Order Pharmacy Name and Patient ID #**

______________________________________________________________

# Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Consent for purposes of treatment, payment and healthcare operations.

I consent to the use or disclosure of any protected health information by Rheumatology Associates of South Florida (R.A.S.F.) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of R.A.S.F. I understand that diagnoses or treatment of me by R.A.S.F. may be conditioned upon my consent as evidence by signature of this document.

I understand I have a right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of R.A.S.F. R.A.S.F. is not required to agree to the restrictions that I may request. However, if R.A.S.F. agrees to a restriction that I request, the restriction is binding on R.A.S.F.

I have the right to prohibit the sale of protected health information, its use for marketing purposes or participation in research.

I have the right to be notified if there is a breach of unsecured protected health information.

I have the right to revoke this consent in writing, at any time, except to the extent that R.A.S.F. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and collected or received by my physician, another health care provider, a health plan, my employer, or an electronic medical records system. This protected health information relates to my past, present, or future physical or mental condition that identifies me, or there is a reasonable basis to believe this information may identify me.

I understand I have a right to review R.A.S.F. notice of privacy practices prior to signing this document. The R.A.S.F. notice of privacy practices have been provided to me. The notice of privacy practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations at R.A.S.F. This notice of privacy practices also describes my rights and the R.A.S.F. duties with respect to my protected health information.

R.A.S.F. reserves the right to change the privacy practices which are described in the notice of privacy practices. I may retain a revised notice of privacy practices by calling the office or asking for one at my next scheduled visit.

____________________________ ____________________

Printed Name of Patient　　　　Date

____________________________

Signature of Patient

____________________________

Description of Personal Representatives Authority

I consent that any R.A.S.F. employee may leave messages on my answering machine at home or on my cell phone.

____________________________

Signature of Patient

I consent that any R.A.S.F. employee may confer with the people listed below.

| Name | Relationship to patient |
|---|---|
| ____________ | ____________ |
| ____________ | ____________ |
| ____________ | ____________ |

**Boca Raton** | Boca Raton Medical Plaza | 1050 N.W. 15th Street, Suite 208A | Boca Raton, Florida 33486 | 561.368.5611
**Delray Beach** | 5162 Linton Boulevard, Suite 101 | Delray Beach, Florida 33484 | 561.498.1114

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Date ________________________

Patient's Name ____________________________________________ Date of Birth ________________

## LIFETIME AUTHORIZATION

Charges for medical services are due and payable at time services are rendered. We will file your insurance if the doctor you are seeing is a provider of your plan. All balances not paid by your insurance carrier are your responsibility to pay.

I certify that the information given by me, in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration intermediaries or carrier of any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

**I request that, the authorization also apply to all other insurances.**

Name ________________________________________________________________________

Signature ________________________________________________ Date ________________

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## General Consent for Care and Treatment Consent

*TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that additional testing, invasive or interventional, may be necessary.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____________________________________ ____________________

Signature of Patient or Personal Representative | Date

Printed Name of Patient or Personal Representative | Relationship to Patient

Printed Name of Witness | Employee Job Title

Signature of Witness | Date

Date ___________________________

Patient Name ______________________________________________ Date of Birth __________________

Advance care planning is making decisions about the care you would want to receive if you become unable to speak for yourself. These are your decisions to make, regardless of what you choose for your care, and the decisions are based on your personal values, preferences, and discussions with your loved ones.

Do you have an Advance care plan? ☐ Yes ☐ No

Do you have a surrogate decision maker? ☐ Yes ☐ No

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Date ____________________________

Patient's Name ______________________________________________ Date of Birth ________________

## REVIEW OF SYSTEMS

**Please circle any that apply:**

**General**: Fatigue | Fever | Chills | Weight loss

**Skin**: Rash | Hair loss | Itchy skin | Sun sensitivity | Skin thickening

**Eyes**: Acute visual change | Eye redness | Eye dryness

**ENT**: Mouth sores | Dry mouth | Sore throat | Nose bleeds | Chronic sinus problems | Hearing impairment | Vertigo

**Lungs**: Shortness of breath | Cough

**CV**: Chest pain | Swelling of legs | Blue/white fingers or toes

**GI**: Abdominal pain | Diarrhea | Constipation | Heartburn | Nausea | Difficulty swallowing | Blood in stool

**GU**: Burning with urination | Blood in urine | Incontinence

**Neuro**: Numbness | Weakness | Headache | Seizures

**Psych**: Anxiety | Depression

**Musculoskeletal**: Joint pain | Joint swelling | Muscle pain

**Other**: ______________________________________________________________________

__________________________________________________________________________________

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Date ____________________

Patient's Name ________________________________ Date of Birth ______________

What is your main reason for today's visit? ________________________________

________________________________________________________________

List all other physicians you have seen for this problem ____________________

________________________________________________________________

Diagnosis given ________________________________________________

## MEDICAL HISTORY

**Please circle any that apply:**

**Skin**: Psoriasis | Eczema

**Eyes**: Dry eye | Glaucoma | Cataracts | Uveitis | Macular degeneration

**Ears and Nose**: Allergic rhinitis | Sinusitis | Vertigo

**Lungs**: COPD | Asthma | Fibrosis/ILD | Pulmonary hypertension

**Cardiovascular**: Coronary artery disease (heart attack) | Raynaud's | Atrial fibrillation | Valvular heart disease | Peripheral arterial disease | High blood pressure | Cholesterol, triglycerides

**Gastrointestinal**: GERD | Peptic ulcer disease | Diverticulosis | Irritable bowel syndrome | Colitis

**Genitourinary**: Chronic kidney disease | Enlarged prostate

**Neurologic**: Stroke | Neuropathy | Seizure disorder | Migraines

**Endocrine**: Diabetes mellitus | Hypothyroid (low thyroid) | Hyperthyroid

**Cancer**: Breast | Prostate | Skin (basal, squamous, melanoma) | Colon | Lung | Lymphoma | Other:

**Musculoskeletal**: Osteopenia | Osteoporosis | Osteoarthritis | Spinal stenosis | Chronic back pain | Fibromyalgia

**Autoimmune/inflammatory**: Rheumatoid arthritis | Lupus (SLE) | Psoriatic arthritis | Gout | Pseudogout | Scleroderma | Sjogren's syndrome | Polymyalgia rheumatica | Giant cell arteritis | Vasculitis

**Other**: ________________________________________________________

________________________________________________________________

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## SURGICAL HISTORY

________________________________ Date______________

________________________________ Date______________

________________________________ Date______________

________________________________ Date______________

________________________________ Date______________

________________________________ Date______________

________________________________ Date______________

## OCCUPATIONAL/SOCIAL HISTORY

You live with ________________________________

If you presently smoke: Packs per day ______________ Years ______________

If you are a former smoker, when did you stop ________________________________

Do you drink alcohol? Yes ________ No ________ If yes, how many drinks per week? ______________

Do you exercise? Yes ________ No ________

If yes, what type of exercise? ________________________________

________________________________

________________________________

________________________________

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Patient's Name ______________________________ Date of Birth ______________

## FAMILY HISTORY

| Parents | | Age | Alive | Dead | Illnesses |
|---|---|---|---|---|---|
| | Father | | | | |
| | Mother | | | | |
| Siblings | | | | | |
| | Brothers | | | | |
| | 1 | | | | |
| | 2 | | | | |
| | 3 | | | | |
| | 4 | | | | |
| | 5 | | | | |
| | 6 | | | | |
| | Sisters | | | | |
| | 1 | | | | |
| | 2 | | | | |
| | 3 | | | | |
| | 4 | | | | |
| | 5 | | | | |
| | 6 | | | | |
| Children | | | | | |
| | Sons | | | | |
| | 1 | | | | |
| | 2 | | | | |
| | 3 | | | | |
| | 4 | | | | |
| | Daughters | | | | |
| | 1 | | | | |
| | 2 | | | | |
| | 3 | | | | |
| | 4 | | | | |

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Date ______________________

Patient's Name ______________________________________________ Date of Birth _______________

## MEDICATIONS

| Name of Drug | Dose (Mg) | How often do you take it? |
|---|---|---|
| | | |
| | | |
| | | |
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Do you take any over-the-medications or supplements? Please list: ________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Medication allergies: If NO, please check __________

If YES, please list medications: ______________________________________________________

______________________________________________________________________________