EASTSIDE RHEUMATOLOGY

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Snellville, GA 30078-0308
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PLEASE COMPLETE THESE FORMS AND BRING THEM TO THE REGISTRATION DESK ALONG WITH YOUR INSURANCE CARD

NAME OF YOUR REFERRING PHYSICIAN _____

PATIENT NAME _____
FIRST MIDDLE LAST AGE DATE OF BIRTH

ADDRESS_____
STREET APT # CITY STATE ZIP CODE

HOME PHONE (_____) _____ **CELL PHONE** (_____) _____ **SS#** _____

EMAIL ADDRESS _____

EMPLOYER _____ **WORK PHONE** (_____) _____

OCCUPATION _____ □ **SINGLE** □ **MARRIED** □ **WIDOWED** □ **DIVORCED** □**MALE** □ **FEMALE**

SPOUSE'S NAME_____ **EMPLOYER**_____ **PHONE**_____

NEAREST RELATIVE NOT LIVING IN YOUR HOME

NAME_____ **ADDRESS**_____ **PHONE**_____

(Complete this box ONLY if patient is a minor)

BILLING / RESPONSIBLE PARTY INFORMATION

FATHER'S NAME_____
ADDRESS _____
_____
HOME PHONE _____
SS#/ DATE OF BIRTH _____

MOTHER'S NAME_____
ADDRESS _____
_____
HOME PHONE_____
SS#/ DATE OF BIRTH_____

WHO IS RESPONSIBLE FOR PAYMENT? _____

INSURANCE INFORMATION

PRIMARY INS _____
POLICY ID # _____
NAME OF POLICY HOLDER_____
DATE OF BIRTH/ SS# _____
RELATIONSHIP TO PATIENT_____
REFERRAL NEEDED FOR THIS INS?_____
ARE YOU REQUIRED TO GO TO A SPECIAL LAB OR HOSPITAL?_____

SEC INS _____
POLICY ID # _____
NAME OF POLICY HOLDER_____
DATE OF BIRTH/ SS#_____
RELATIONSHIP TO PATIENT_____
REFERRAL NEEDED FOR THIS INS?_____
ARE YOU REQUIRED TO GO TO A SPECIAL LAB OR HOSPITAL?_____

Your health insurance program may have limits that will affect your charge at ***Eastside Rheumatology****. Some insurance companies will not pay for certain tests or office visits and will be your responsibility. We accept assignment with numerous insurance carriers. Please check with our front desk to identify your insurance carrier. If you do not have insurance through one of these carriers, then you are responsible for submitting claims and payment will be due at the time of service.*
I HAVE READ AND UNDERSTAND THE ABOVE, and hereby give my consent to any physician member of Eastside Rheumatology or designee to provide medical treatment to me encompassing diagnostic and therapeutic procedures.

_____ _____
Patient (or Responsible Party) Signature **Date**

Eastside Rheumatology and Internal Medicine
1567 Janmar Road Suite 100
Snellville, GA 30078
Ph: 770-972-1022

Patient History Form

Name: _____ **Birthdate:** _____
L AST FIRST MIDDLE NITIAL MAIDEN

MARITAL STATUS: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Occupation _____ Name of person making referral: _____

Referred here by: (check one): ○ Self ○ Family ○ Friend ○ Doctor ○ Other Health Professional

The name of the physician providing your primary medical care: _____

Describe briefly your present symptoms:

_____

_____

Date symptoms began (approximate): _____

Diagnosis: _____

_____

Previous treatment for this problem (include physical therapy, surgery and injection; medication to be listed later)

_____

_____

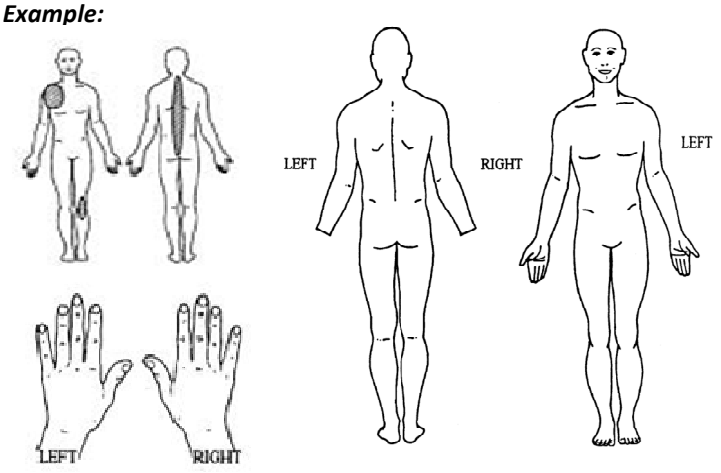
Please list the names of other practitioners you have seen for this problem:

_____

_____

*Please shade all the locations of your pain **over the past week** on the **body figures** and **hands***

Example:



RHEUMATOLOGIC (ARTHRITIS HISTORY)
At any time have you or a blood relative had any of the following? (Check if "yes")

Yourself		Relative Name/ Relationship	Yourself		Relative Name/ Relationship
	Arthritis (unknown type)			**Lupus or "SLE"**	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Rheumatology New Patient form

Mother Medical History: _____

Father Medical History: _____

Allergies to Medications: _____

Current Medications with Dose and Frequency:

_____ _____

_____ _____

_____ _____

Past Medical History: **Please list all the diagnosis:** _____

_____

ROS : **Please check if you have the following:**

Allergy symptoms ___ Bleeding ___ Breathing difficulties, respiratory problems ___

Cardiovascular problems, chest symptoms ___ Fever, headache, nausea, dizziness ___

Endocrine problems, increased thirst or urination ___ eye or vision problems ___

GI symptoms ___ GU symptoms ___ Joint or musculoskeletal symptoms ___

Neurological symptoms ___ Psychiatric or emotional difficulties ___

Skin related symptoms ___ Symptoms involving ear, nose, mouth, or throat ___

Social History : **(write Yes or No)**

Smoking _____ Alcohol use _____ Illegal drug use _____

Surgeries. **Please list all surgeries:**

_____

_____

Eastside Rheumatology

Patient Consent form

(Please Read and Sign)

I, the undersigned, hereby consent to the following:

- Administration and performance on all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests
- Taking and utilization of cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I understand that Eastside Rheumatology includes consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Eastside Rheumatology will use and disclose my information for the purpose of treatment, payment, and healthcare operations.

Treatment includes but is not limited to the administration and performances of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Eastside Rheumatology of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the service provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee understands that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I fully understand that this given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

(OPTIONAL) If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and the _____ Health Department and appropriate counseling will be offered.

(OPTIONAL) MEDICARE PATIENTS: I authorize to release medial information about me to the Social Security Administration or its intermediates for my Medicare claims. I assign then benefits payable for services to Eastside Rheumatology.

I acknowledge that I have been given the Eastside Rheumatology Notice of Privacy Practices. I understand that if I have questions or complains that I should contact the Privacy Official. **Patient Initial:** _____

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

_____ _____

Patient (or Responsible Party) Signature ***Date***

Eastside Rheumatology

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's name:_____ Date of Birth: _____

Individuals Involved in Your Care or Payment for your Care. We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about your condition to an entity assisting in a disaster relief effort so that your family can be notified about your condition status and location.

Below is the name and number of the individual/s that Eastside Rheumatology may release or discuss your health information with:

Name:_____ Phone number:_____

Name :_____ Phone number:_____

PRESCRIPTION REFILL REQUEST POLICY

Due to high numbers of medication errors between pharmacies and medical offices, our office has decided to implement a refill request policy. We feel that this will cut on any errors with your medications.

Please contact your pharmacy and have the pharmacy fax over a refill request. **We will refill prescriptions within 48-72 hours of receiving the request from your pharmacy. Our fax number is 770-407-8584.** We appreciate your help in this matter and look forward to caring for your healthcare needs.

OFFICE POLICIES

- THERE WILL BE A **$30.00** CHARGE FOR RETURNED CHECKS.
- THERE WILL BE A **$25.00** CHARGE FOR MISSED APPOINTMENTS WITHOUT A 24-HOUR NOTICE.
- THERE WILL BE A **$25.00** CHARGE FOR COMPLETION OF SPECIAL FORMS BUT NOT LIMITED TO THESE:
    - HANDICAP
    - DISABILITY
- IT IS YOUR RESPONSIBILITY TO CHECK WITH YOUR INSURANCE COMPANY FOR PLAN PARTICIPATION. IF BENEFITS ARE NOT COVERED AT A 100%, YOU ARE RESPONSIBLE FOR THE DIFFERENCE/FULL PAYMENT.
- ***ALL CO-PAYS, CO-INSURANCES OR DEDUCTIBLES ARE COLLECTED PRIOR TO SEEING THE PHYSICIAN***.

By signing this, I acknowledge that I have read and understand the above policies.

Patient's Signature: _____**Date**: _____