

OFFICE USE ONLY	PATIENT NUMBER	TYPE OF EXAM	DOCTOR/NUMBER	<input type="checkbox"/> SMOKER <input type="checkbox"/> NON-SMOKER	BY:
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PATIENT INFORMATION
Please Print - ALL UNSHADED AREAS

PATIENT

NAME FIRST - MIDDLE - LAST			AGE	TODAY'S DATE	
STREET ADDRESS			CITY	STATE	ZIP
PRIMARY PHONE ()	ALTERNATE PHONE ()	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> DIV <input type="checkbox"/> SEP <input type="checkbox"/>	DATE OF BIRTH	SOCIAL SECURITY NUMBER
EMPLOYER NAME AND ADDRESS (IF MINOR, MOTHER'S NAME)			PATIENT'S EMAIL ADDRESS		

SPOUSE OR RESPONSIBLE PARTY

NAME first-middle-last (if minor, father's name)	RELATIONSHIP (mother, father, etc.)	SOCIAL SECURITY NUMBER	CELL PHONE ()	HOME PHONE ()
DATE OF BIRTH	STREET ADDRESS	CITY	STATE	ZIP
EMPLOYER NAME AND ADDRESS		CITY-STATE-ZIP	PHONE ()	OCCUPATION

EMERGENCY CONTACT AND PHARMACY INFORMATION

PERSON TO CONTACT IN EMERGENCY (NEXT OF KIN)	THEIR RELATIONSHIP TO YOU	CELL PHONE ()	HOME PHONE ()
PHARMACY NAME	ADDRESS	PHONE ()	

MEDICAL COMPLAINT (PART OF BODY) AND PRIOR TREATMENT

EXPLAIN	DURATION
REFERRING PHYSICIAN	ADDRESS / PHONE
FAMILY PHYSICIAN	ADDRESS / PHONE
INSURANCE INFORMATION	
INSURANCE COMPANY	INSURANCE COMPANY
<input type="checkbox"/> HMO COPAY \$ _____ <input type="checkbox"/> PPO COPAY \$ _____	<input type="checkbox"/> HMO COPAY \$ _____ <input type="checkbox"/> PPO COPAY \$ _____
POLICY NUMBER	POLICY NUMBER
GROUP NUMBER	GROUP NUMBER
<input type="checkbox"/> AUTHORIZATION <input type="checkbox"/> REFERRAL	<input type="checkbox"/> AUTHORIZATION <input type="checkbox"/> REFERRAL

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of all medical information necessary to process this claim and is pertinent to my medical care. I assign all medical and/or surgical benefits to **ORLANDO ARTHRITIS INSTITUTE**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. ALL COSTS INCURRED IN COLLECTING ANY OUTSTANDING DEBTS WILL BECOME THE FULL RESPONSIBILITY OF THE PATIENT. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

MEDICARE AUTHORIZATION TO RELEASE INFORMATION AND MEDICAL ASSIGNMENT

I request that payment of authorized Medicare benefits be made on my behalf to **ORLANDO ARTHRITIS INSTITUTE** for any services furnished me. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR NON-COVERED SERVICES AS EXPLAINED TO ME BY THE PHYSICIAN. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

SIGNATURE (parent if minor)	Date
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ALLERGIES:

FINANCIAL POLICY

- **COPAYMENTS ARE EXPECTED TO BE PAID IN FULL AT THE TIME OF EACH OFFICE VISIT.**

OUR OFFICE OFFERS THE FOLLOWING PAYMENT OPTIONS:

1. CASH
2. CHECK (\$25.00 SERVICE CHARGE ON RETURNED CHECKS)
3. CREDIT CARD (MASTERCARD OR VISA)

- **WE REQUIRE A MINIMUM OF 24 HOURS NOTICE FOR ALL CANCELLED APPOINTMENTS. FOR MISSED APPOINTMENTS WITHOUT 24 HOURS NOTICE, THERE WILL BE A CHARGE OF \$25.00. THESE CHARGES WILL BE THE RESPONSIBILITY OF THE PATIENT. MISSED APPOINTMENTS WITHOUT 24 HOURS NOTICE MAY RESULT IN THE PATIENT BEING DISCHARGED FROM THE CLINIC.**
- **WE WILL FILE YOUR INSURANCE IF AUTHORIZATION FOR TREATMENT HAS BEEN OBTAINED. IT IS YOUR RESPONSIBILITY TO HAVE A VALID REFERRAL OR AUTHORIZATION BEFORE BEING SEEN. UNFORTUNATELY, WE ARE NOT PARTICIPATING PROVIDERS FOR ALL INSURANCE PLANS. PLEASE CHECK WITH YOUR INSURANCE COMPANY BEFORE SCHEDULING AN APPOINTMENT. EVEN THOUGH WE DO FILE YOUR INSURANCE, PAYMENT IS YOUR RESPONSIBILITY. WE EXPECT YOU TO KEEP YOUR ACCOUNT CURRENT.**
- **FOR PATIENTS WITH INSURANCE COVERAGE, IT IS OUR POLICY TO REQUEST AN ESTIMATED PORTION OF THEIR FINANCIAL RESPONSIBILITY TO BE PAID AT THE TIME OF EACH VISIT. IN MAKING THIS DETERMINATION, WE WILL MAKE EVERY EFFORT TO BE AS ACCURATE AS POSSIBLE, HOWEVER, IT IS NEARLY IMPOSSIBLE TO BE EXACT WITH SO MANY COVERAGES AVAILABLE.**
- **ANY QUESTIONS REGARDING OUR PAYMENT POLICIES MAY BE DISCUSSED WITH THE BUSINESS MANAGER.**

I understand and agree to the above written policy.

Patient's Signature

Date

Responsible party if other than Patient

Date

Orlando Arthritis Institute

Javaid S. Sheikh, M.D., M.R.C.P
Rheumatology / Immunology

SPECIAL MEDICAL INFORMATION RELEASE FORM

I HEREBY GIVE AUTHORIZATION FOR RELEASE OF MY MEDICAL RECORDS TO

NAME

ADDRESS

CHECK EACH LINE THAT APPLIES IF THIS INFORMATION IS TO BE RELEASED.

- Any information acquired in the course of my examinations and / or treatment contained in the chart at Orlando Arthritis Institute.
- My diagnosis and / or treatment for alcoholism and / or drug abuse or dependency may be released to the recipient noted above.
- My diagnosis and / or treatment concerning mental health / rehabilitation may be released to the recipient noted above.
- HIV antibody test results and / or AIDS diagnosis and treatment may be released to the recipient noted above.
- X-rays

I understand that this consent will remain in effect until revoked by me in writing.

SIGNED: _____
(IF UNDER 18 YEARS OF AGE, PARENT OR GARDIAN MUST SIGN.)

DATE: _____

Patient's name as it appears on records / Date of Birth

Chart #

Doctor

Orlando Arthritis Institute

Name _____ SS# _____ Date _____

Sex _____ Date of Birth _____ Age _____ Chief Complaint _____

DRUG ALLERGIES

CURRENT MEDS

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY:

Pregnant? Yes No Planning Pregnancy? Yes No

MEDICAL HISTORY

- | | | |
|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Lactose intolerance | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Prostate disease | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> bowel irregularity | <input type="checkbox"/> Chronic rashes |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Sexual/menstrual dysfunction | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Allergies/Hay fever | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other |
| <input type="checkbox"/> GI disorder | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Other |

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
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood arthritis	<input type="checkbox"/>	Osteoporosis

Other arthritis conditions: _____

ORLANDO ARTHRITIS INSTITUTE, P.A.

58 W. MICHIGAN ST.

ORLANDO, FL 32806

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

I, _____, have received a copy of Orlando
Arthritis Institute's Notice of Privacy Practices.

SIGNATURE OF PATIENT

DATE

24 Hour Cancellation and "No Show" Fee Policy

Recognizing that everyone's time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment.

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

For missed appointments without 24 hours notice, there will be charge of \$25.00.

These charges will be responsibility of the patient. Multiple "No Shows" in any 12 month period will result in termination from our practice.

Thank you for your anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

Printed, Last Name, First

Date

Signature



Javaid S. Sheikh, M.D., F.A.C.P., M.R.C.P.
ORLANDO ARTHRITIS INSTITUTE
Rheumatology / Immunology

By signing this authorization, I authorize Orlando Arthritis Institute to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits Orlando Arthritis Institute to use and/or disclose the following individually identifiable health information about me (specifically describe the information, etc.):

This information will be used or disclosed for the following purpose: _____

If requested by the patient, purpose may be listed as "at the request of the individual". The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This release will expire on _____.

The Practice will will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Orlando Arthritis Institute. In fact I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the Practice has acted in reliance upon this authorization. My written revocation must be submitted to:

Orlando Arthritis Institute
58 W. Michigan St.
Orlando, FL 32806

Signed by: _____ Relation to Patient: _____

Patient name: _____ Date: _____

Print Name of Patient or Legal Guardian: _____