OFFICE USE ONLY	PATIENT NUMBER	TYPE OF EXAM	DOCTOR/NUMBER	☐ SMOKER ☐ NON-SMOKER	BY:

PATIENT INFORMATION

Please Print - ALL UNSHADED AREAS

PATIENT

NAME FIRST - MIDDLE - LAST			AGE	TODAY'S DATE
STREET ADDRESS		CITY	STATE	ZIP
HOME PHONE ( )	WORK PHONE ( )	SEX ☐M ☐F	MARITAL STATUS S☐ M☐ W☐ DIV☐ SEP☐	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	HOME PHONE ( )	WORK 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	HOME PHONE ( )	WORK 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		SECONDARY CARRIER	
INSURANCE COMPANY	☐ HMO COPAY $_____ ☐ PPO COPAY $_____	INSURANCE COMPANY	☐ HMO COPAY $_____ ☐ PPO COPAY $_____
POLICY NUMBER		POLICY NUMBER	
GROUP NUMBER	☐ AUTHORIZATION ☐ REFERRAL	GROUP NUMBER	☐ AUTHORIZATION ☐ 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

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

Dr. Javaid Sheikh
NAME

58 W Michigan St.
ADDRESS

Orlando, FL 32806

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 alchoholism and / or drug abuse or dependancy 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: _____ DATE: _____
(IF UNDER 18 YEARS OF AGE, PARENT OR GARDIAN MUST SIGN.)

_____
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	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Hospitalization or Surgery

Reason	*Date*	*Reason*	*Date*

Women Only: Pregnant? ☐ Yes ☐ No Planning Pregnancy? ☐ Yes ☐ No

Medical History

☐ Headache _____
☐ Shortness of breath _____
☐ Heart palpitations _____
☐ Heart murmur _____
☐ Chest pain _____
☐ Dizziness/Fainting _____
☐ Peripheral vascular disease _____
☐ Allergies/Hay fever _____
☐ Asthma _____
☐ Bronchitis _____
☐ Pneumonia _____
☐ Ulcer _____
☐ GI disorder _____

☐ Lactose intolerance _____
☐ Gallbladder disease _____
☐ Prostate disease _____
☐ bowel irregularity _____
☐ Incontinence _____
☐ Sexual/menstrual dysfunction _____
☐ Venereal disease _____
☐ Frequent infections _____
☐ Hepatitis _____
☐ Anemia _____
☐ Arthritis _____
☐ Osteoporosis _____
☐ Nervousness _____

☐ Depression _____
☐ Gout _____
☐ Scarlet fever _____
☐ Chronic rashes _____
☐ Rheumatic fever _____
☐ Mumps _____
☐ Measles _____
☐ Rubella _____
☐ Polio _____
☐ Diptheria _____
☐ Tetanus _____
☐ Other _____
☐ 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
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

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: _____

ORLANDO ARTHRITIS INSTITUTE, P.A.
58 West Michigan Street
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**