Welcome, and thank you for choosing Cape Fear Arthritis Care. We are happy to have you as our patient! Please read and **complete these forms BEFORE you arrive for your appointment**, and bring everything with you, including **your insurance card(s) and a photo ID**. This document contains important information about our office policies and procedures. **If you have any questions about this information, please feel free to call us at 910-679-3212 x 701. Our Patient Advocate is happy to help you!**

**Paperwork Reduction:** This is a “green” practice- we use an Electronic Health Records (EHR) system compliant with all federal standards, and we strive to keep paperwork to a minimum (we don’t even send out patient statements!). We have reduced the number of forms you have to fill out to the absolute minimum necessary. We do ask that you be as thorough as possible in order to give our providers the information needed to assess and treat your condition(s) properly.

**Medication Refills:** Refills are handled through our EHR system. If you are out of refills, please contact your pharmacy and they will notify us.

**Lab Results:** If your provider orders labs or other testing for you, we will schedule a return visit so he/she may discuss those results with you. Lab results are also available via our Patient Portal- you will be given instructions to access it via email after your first visit. The portal does NOT replace the need for a face-to-face discussion of the results with your provider.

**Health Insurance:** We have already contacted your insurance plan/Medicare/Medicaid to verify your current eligibility for coverage, as well as any copay/deductible/coinsurance that applies to your benefit plan. Those amounts are due at the time of service. We will file a claim with your primary and secondary insurance (if any); you will receive an Explanation of Benefits notice from your insurance plan showing how they processed your claim. That document will serve as your notice if there is any additional balance due, beyond what we collected from you at the time of service. PLEASE NOTE: We do not choose your benefits and are not responsible for how your plan processes your claims or calculates your benefits, so please refer any questions about those issues to your insurance company or employer plan administrator.

**Cancelling/Rescheduling Appointments:** Keeping your appointments as scheduled is an important part of complying with your plan of care and helping us serve all patients in a timely manner. We understand that occasionally circumstances arise that you can’t anticipate. If you are unable to keep a scheduled appointment, we require a MINIMUM of 24 hours prior notice so we can contact a patient on our waiting list to take your place. Fees for missed appointments are as follows: $100 for initial visit, $50 for follow up visit, and $100 for infusion and physical therapy visits. While we try to call patients to give reminders, it is the patient’s responsibility to keep track of scheduled appointments. Just because you don’t get a reminder call from us doesn’t mean you don’t have a scheduled appointment.

Financial Policy

**Please read this policy thoroughly. If you have questions, please call us prior to your first visit.**

Cape Fear Arthritis Care is a family-owned practice. **We are not a part of, nor do we receive any financial support from, any healthcare corporation or hospital.** Patients come first at our practice! We believe independent physician practices provide the best care and patient experience, and we want to continue to provide a friendly and caring atmosphere to serve our patients. **But the economic realities of being “on our own” mean that our financial policies may be different from what you are accustomed to at other corporate or hospital-owned practices.**  We do not send bills to our patients - we depend solely on our patients to comply with our financial policy to help us keep our doors open so that we may serve you and give you the best and most personalized rheumatologic care available anywhere.

**Copays, Deductibles, and Coinsurance:** We contact your insurer(s) to verify your benefits prior to each visit to determine what amount your insurance does not pay for, and we will collect that amount at the time of your visit. Since your insurance coverage is a contract between you or your employer and the insurance company, we do not determine what your benefits are. We simply file claims for services rendered, and your insurance carrier is free to process them as they see fit. **Please refer to the Explanation of Benefits they send you to answer any questions you have about how they processed your claim.**

We do our best to collect the correct amount at the time of service, but we have no control over how your insurance plan chooses to administer your benefits. If your insurance does not pay/denies the claim, or they pay less than they told us they would, we will charge that amount (up to $200) to your credit card on file. **If you believe your insurance denied/or processed your claim in error, please call us immediately to allow you to talk with your insurance company BEFORE we charge your card.** For amounts over $200, we will call you before charging your card. **We have no access to your full credit card number**- it is stored and encrypted by a certified company that is compliant with all federal privacy laws. If your insurance pays more than they said they would, we will apply the credit to your account and you may use it at your next visit, or receive a refund of the overpayment, whichever you choose.

Financial Agreement:

*I authorize Cape Fear Arthritis Care to automatically charge my credit/debit/or HSA card on file for any balance that is owed after insurance and point of service (patient) payments for a particular date of service have been applied to my account. This authorization is valid without any additional consent on my part, up to an amount of $200. For balances due over $200, I agree to recurring payments of $50.00 on the 1st day of each month using the specified card on file, continuing until the balance due is paid in full.*

Printed name of patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Registration Form PLEASE PRINT CLEARLY**

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First MI Last

Date of Birth\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone Number: \_\_\_\_ Home \_\_\_\_ Cell \_\_\_\_Work

**If patient is under 21:**

Are the parents \_\_\_\_\_Married \_\_\_\_\_ Divorced \_\_\_\_\_Unmarried

Who is the custodial parent?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, whom should we call?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

* I authorize insurance payment of medical benefits to Cape Fear Arthritis Care for services rendered. I understand that I am financially responsible for any services no covered by insurance carrier(s).
* I authorize Cape Fear Arthritis Care to treat me and use my personal health information necessary to complete and process my insurance claims.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Patient/responsible party signature

**Patient Rights and Responsibilities**

We believe it is important for patients to know what they should expect from us AND what is expected from them, so we have prepared this short list of patient rights and responsibilities.

**Patients have the right to:**

* --Quality medical care in a safe environment
* --Be treated with respect and dignity
* --Understand their treatment plan

**Patients have the RESPONSIBILITY to:**

* --Keep their scheduled appointments or give **at least 24 hours notice** if unable to do so
* --Follow their prescribed course of treatment or discuss it with the practitioner if unable/unwilling to do so
* --Pay amounts not covered by insurance promptly.

We understand that occasionally you may not be able to keep a scheduled appointment- all we ask is that you give us enough notice so we can contact another patient on our waiting list so he/she can be seen at that time. Our current waiting time for appointments is 6 weeks- that is a long time to wait if you’re in pain!- and we believe it is simple courtesy to let someone else have your appointment time if you can’t be here.

We at Cape Fear Arthritis Care want your experience here to be a pleasant one. If you have any questions/concerns about our office policies, please feel free to ask to speak with our Practice Administrator or Chief Operating Officer. We are happy to help you!

**HIPAA DISCLOSURE AUTHORIZATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Cape Fear Arthritis Care to speak with and disclose information about my medical care and conditions to the following persons:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I further authorize Cape Fear Arthritis Care to contact me by:

\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization will remain in place until rescinded by me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient Signature)

**Defining Pain**

Everybody experiences pain differently. How one experiences pain is at least as important as what is causing pain. For this reason, we need some standards in how to define pain. Below is a pain scale. Please read it carefully, then use the numbers to answer the following questions.

1. No Pain.

|  |  |  |
| --- | --- | --- |
| Mild Pain- Nagging, annoying, but doesn’t really interfere with daily living activities. | Moderate Pain- Interferes significantly  with daily living activities | Severe Pain-Disabling; unable to perform daily living activities. |
| 1 – Pain is very mild, barely noticeable. Most of the time you don’t think about it. | 4 – Moderate pain. If you are deeply involved in an activity, it can be ignored for a period of time, but it is still distracting. | 7- Severe pain that dominates your senses and significantly limits your ability to perform normal daily activities or maintain social relationships. Interferes with sleep. |
| 2 – Minor Pain. Annoying and may have occasional stronger twinges. | 5 – Moderately strong pain. It can’t be ignored for more than a few minutes, but with effort you still can manage to work or participate in some social activities. | 8 – Intense pain. Physical activity is severely limited. Conversing requires great effort. |
| 3 – Pain is noticeable and distracting, however, you can get used to it and adapt. | 6 – Moderately strong pain that interferes with normal daily activities. Difficulty concentrating. | 9 – Excruciating pain. Unable to converse. Crying out and/or moaning uncontrollably. |
|  |  | 10 – Unspeakable pain. Bedridden and possibly delirious. Very few people will ever experience this level of pain. |

What number corresponds to your pain right now?\_\_\_\_\_\_\_\_\_\_\_

What is the highest number of pain you experience?\_\_\_\_\_\_\_\_\_\_

When do you have that level of pain and what makes it worse

What is the lowest number of pain you experience?\_\_\_\_\_\_\_\_\_\_\_

What gives you pain relief?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the average level of discomfort you have had for the past 2 weeks?\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your pain worse in the morning when you first get up?\_\_\_\_\_\_\_\_\_ What number?\_\_\_\_\_\_\_\_

Is your pain worse with activity during the day?\_\_\_\_\_\_\_\_\_\_\_\_ What number?\_\_\_\_\_\_\_\_\_\_

**Ability to Function**

For each of the following, please mark the response that best describes your ability.

Without ANY With SOME With MUCH UNABLE

difficulty difficulty difficulty to do

Dress yourself, including tying shoelaces

and doing buttons \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Get in and out of bed \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Lift cup or glass to your mouth \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Walk outdoors on flat ground \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Wash and dry entire body \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Pick up something off the floor \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Turn a doorknob or faucet \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Get in & out of the car \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**System Review Sheet**

Circle any symptoms you have had in the past 12 months and add comments

|  |  |  |
| --- | --- | --- |
| **General**  Recent weight change  Fatigue  Weakness  Fever  Night Sweats  **HEENT**  Dry eyes  Dry mouth  Visual change or loss  Oral Ulcers  Eye pain, irritation, redness  Increase in dental cavities  Nosebleeds  Hoarseness  Difficulty swallowing  Pain in jaw while chewing  **Neck**  Swollen glands  Tender glands | **Heart and Lungs**  Chest discomfort  Pain with breathing or coughing  Irregular or rapid heartbeat  Shortness of breath  Cough- Productive Y/N  Wheezing  **Abdomen**  Abdominal pain or discomfort  Bloating  Nausea  Vomiting  Persistent diarrhea  Constipation  Heartburn  **Genitourinary**  Sexually transmitted disease  Pain on urination  Blood in urine  Rash, dryness, ulcers  **Blood**  Anemia  Bleeding tendency | **Skin**  Easy bruising  Rash from sun exposure  Skin tightening  Nodules or bumps  Hair loss  Other rash  Psoriasis  Nail changes  **Extremities**  Swelling  Color changes such as blue or white with cold exposure  **Nervous system**  Headaches  Dizziness  Numbness/tingling in hands/feet  --Intermittent  --Permanent  Memory loss  Muscle weakness |

Pertinent medical history:

Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal past medical history: Please list all diseases or conditions that you are now or have been treated for in the past:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past surgical history: Please list previous surgeries and year performed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serious injuries or hospitalizations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Health maintenance: Last chest x-ray\_\_\_\_\_\_\_\_\_\_\_\_\_\_, TB test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Colonoscopy\_\_\_\_\_\_\_\_\_\_\_\_\_Eye exam\_\_\_\_\_\_\_\_\_\_\_\_

Bone Mineral Density test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you been treated for low bone mass/osteoporosis?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family history: Please list all conditions family members have been diagnosed with, including parents, cousins, grandparents, siblings, aunts, uncles\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- |
| Prescription Medication | Purpose or  Reason Taken | Dose | Time(s)  Of Day | Form  (Liquid, capsule, tablet) | Special Instructions |
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| Over the Counter/  Vitamins/Supplements | Purpose or  Reason Take | Dose | Time(s)  Of Day | Form  (Liquid, capsule, tablet) | Special Instructions |
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Primary Care Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_