ARTHRITIS AND RHEUMATIC DISEASE ASSOCIATES, P.C.

PLEASE PRINT PATIENT INFORMATION

NAME_____TODAY'S DATE_____

AGE_____ DATE OF BIRTH_____ SS#_____

ADDRESS_____CITY_____ STATE_____ ZIP_____

HOME PHONE_____ BUSINESS PHONE_____ CELL PHONE_____

OCCUPATION_____

EMPLOYER_____ ADDRESS_____

NUMBER OF CHILDREN AND AGES_____

MARITAL STATUS: S M W D SEP SPOUSE'S NAME_____

SPOUSE'S EMPLOYER_____ADDRESS_____

OCCUPATION_____

PATIENT REFERRED BY_____ PHONE #_____

ADDRESS_____

PERSON RESPONSIBLE IF PATIENT IS A MINOR OR STUDENT:

NAME_____ ADDRESS_____

PHONE_____ OCCUPATION_____ SS#_____

EMPLOYER_____ BUSINESS PHONE_____

BUSINESS ADDRESS_____

PLEASE COMPLETE THE FOLLOWING INSURANCE INFORMATION. THIS INFORMATION IS NEEDED IN THE EVENT THE PATIENT WERE HOSPITALIZED. ALSO, PLEASE SIGN BACK OF THIS SHEET.

INSURANCE COMPANY_____

ADDRESS_____ PHONE_____

POLICY # OR I.D.#_____GROUP #_____CODE #_____

POLICYHOLDER'S NAME_____ SS#_____

POLICYHOLDER'S DOB_____ SIGNATURE_____

IN ORDER TO CONTROL OUR COSTS OF BILLING, WE REQUEST THAT OFFICE VISITS BE PAID AT THE TIME SERVICE IS RENDERED. WE WOULD RATHER CONTROL OUR BILLING COSTS THAN BE FORCED TO RAISE OUR FEES.

PATIENT'S AUTHORIZATION

I,_____, hereby authorize Neil I. Stahl, M.D. to apply for benefits on my behalf for covered services rendered by Neil I. Stahl, M.D. I request payment from _____ be made directly to Neil I. Stahl, M.D.

(INSURANCE COMPANY NAME)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim. I permit a copy for this authorization to be used in place of the original.

This authorization may be revoked by either me or the above carrier at any time in writing. I am responsible for deductibles and co-pays not covered by my insurance.

_____ ____ _____
SIGNATURE OF SUBSCRIBER OR BENEFICIARY DATE

_____
IDENTIFICATION NUMBER

I, the undersigned, hereby acknowledge that I have requested the services of Neil I. Stahl, M.D. either for myself or for another person; and, further, each signatory states and understands that he is jointly and severally liable for the payment of all bills hereby incurred. I also agree to pay reasonable attorney fees should it become necessary for the filing of a civil suit to collect said bills.

There is a $30.00 charge for each returned check.

I will also be responsible for a collection agency fee of 30 percent for all balances remaining unpaid after 90 days, which will be charged to my account.

I will also be responsible for any missed appointments not cancelled at the rate of a Brief Office Visit.

_____ _____
SIGNATURE PATIENT, OR PARENT IF PATIENT IS A MINOR DATE

_____ _____
SPOUSE DATE

**********MANAGED CARE PATIENTS**********

***I understand that if I do not present a valid referral from my primary care physician at the time of service, that I will be responsible for the bill in the event that my claim is denied by my insurance company.

_____ _____
SIGNATURE OF PATIENT, OR PARENT IF PATIENT IS A MINOR DATE

AUTHORIZATION TO LEAVE MESSAGES

In an effort to protect our patients' rights to medical confidentiality, we will leave messages for patients only when they have given their permission. Please indicate your preference regarding the leaving of messages below.

I,_____, grant permission to a representative of Arthritis and Rheumatic Disease Associates, P.C., to do the following:

Leave a message on my answering machine/voice mail or with anyone in my household who answers the telephone.

YES	NO
_____	_____

Some reasons we might leave a message are to confirm the time and date of an appointment or to leave tests results.

If you do not want us to leave messages for you, please check NO above. A YES above indicates your consent.

Your signature below acts as your authorization.

_____ _____

Signature Date

_____

Print name

RESPONSIBILITY FOR PAYMENT OF SERVICES

I, _____, understand that my insurance company, _____, may determine as ineligible payment of certain covered services and may not provide coverage for other services rendered to me by Dr. Neil I. Stahl. Furthermore, I agree to be fully responsibility for the payment of these either noncovered or covered services that are determined to be ineligible for payment to the participating physician (i.e., Dr. Neil I. Stahl) under the terms of my insurance plan.

_____
Signature

_____
Date

Date	Service	Initials

OSTEOPOROSIS QUESTIONNAIRE

PLEASE FILL IN NAME AND DATE

Date _____ Dominant Leg R L

Mr. Mrs. Ms. Miss Dr.
Name_____ Wt_____ Ht_____
Address_____ Sex _____ Age _____
Referring Physician_____ DOB_____ SS#_____

Instructions: If you can answer YES to any of the following statements, CIRCLE THE NUMBER.

1. I have scoliosis (curvature) of the spine.
2. I have had abdominal surgery or spinal surgery with metal clips, staples or rods left in place.
3. I have had hip surgery with metal pins or an artificial hip joint. If so, state which side _____.
4. I am now pregnant.
5. I have had an isotope study such as a bone scan or a thyroid scan in the last month.
6. My ethnic background is Northern European (France, Germany Poland, etc.), British, or Asian-Pacific.
7. I have a family history of osteoporosis or a family history of hip fracture. Specify:_____.
8. I have been told that my bone x-rays show osteoporosis or osteopenia (If so, circle one).
9. I have fractured a wrist, spine, hip, upper arm or upper leg. If your answer was yes, please indicate which bone was fractured and at what age _____Any other fracture: _____.
10. I participate in regular exercise. State type and frequency _____.
11. I drink three or more alcoholic beverages daily.
12. I drink five or more cups of caffeinated coffee or tea daily.
13. I drink five or more caffeinated sodas daily.
14. I smoke or used to smoke 2 or more packs of cigarettes per WEEK. (If quit, _____years ago).
15. My recent dietary intake of dairy products (glass of milk, serving of yogurt, cheese, etc.) is limited to fewer than 2 servings per day.
16. Between childhood and the age of 30, I did not drink milk on a daily or frequent basis.
17. I have a known dietary allergy or intolerance to milk or milk products.
18. I currently take calcium supplements Brand:_____ Milligrams daily:_____for _____months/years.
19. I have taken a corticosteroid medication (cortisone-like drugs such as prednisone, dexamethasone, etc.).
20. I have one or several of the following chronic medical conditions: Inflammatory arthritis such as rheumatoid arthritis, inflammatory bowel disease or a history of having surgical removal of part of my bowel, chronic liver or renal (kidney) disease.
21. I have taken one or several of the following medications (please circle the names of those taken): methotrexate, heparin injections, anticonvulsants (as would be used to combat epilepsy), Lupron depot, antacids containing aluminum, chemotherapy for cancer, lithium, INH, thyroid.
22. I have been diagnosed as having a disease of the parathyroid glands. Please specify _____.
23. I have a history of having an elevated blood level of calcium.
24. I have lost 1½ inches or more in height. What was your full adult height? _____.
25. I have a history of blood clots or phlebitis.
26. I have a history of an eating disorder (such as anorexia nervosa).
27. Please list all of the medications you are taking: _____

OSTEOPOROSIS QUESTIONNAIRE

ANSWER ONLY IF YOU ARE FEMALE

28. At what age did you begin your menstrual periods?_____
29. What is your menopausal status? (check one) _____ Pre-menopausal _____
    Possible early menopause _____Going through menopause now_____Post-menopausal
30. At what age did you complete menopause? _____
31. Did you undergo a hysterectomy?_____Yes_____No If so, at what age? _____
32. Are you currently receiving estrogen replacement therapy? _____ Yes _____ No
    (a)If yes, what kind, what dosage, and for how long?_____
33. Have you had breast cancer? _____ Yes _____ No
34. Do you have a family history of breast cancer? _____Yes _____ No Who?_____
35. Do you have a family history of coronary heart disease? _____ Yes _____ No Who?_____

WHAT IS YOUR CALCIUM INTAKE?

Name_____ Sex: F_____ M_____ Age_____

Please answer the questions only. **Please do not complete this side.**

1. On average, how many 8 oz. glasses of milk (whole milk, reduced-fat milk, skin milk or lactose-free milk) do you drink?
   _____ less than one glass per day _____ 1 glass per day No. of glasses x 300 _____
   _____ 2 glasses per day _____ more
2. On average, how often do you eat a serving (1/2 cup cooked) of deep-green vegetables (broccoli, kale, collard greens, etc.)?

   ____ daily ____3x a week ____weekly ____never No. of servings x 150 _____
3. On average, how often do you eat a serving (1 oz.) of hard cheese (parmesan, cheddar, swiss, etc.)?

   ____ daily _____3x a week _____ weekly _____never No. of servings x 200 _____
4. On average, how often do you eat a serving (1 cup) of yogurt?
   _____daily ____ 3x a week _____ weekly ____ never No. of cups x 400_____
5. On average, how often do you eat a serving (1/2 cup; approximately 1 large scoop) of premium or low-fat ice cream?
   _____ daily ____ 3x a week _____weekly _____ never No. of 1/2 cups x 85
   _____
6. Do you eat any calcium-fortified foods such as cereals, juice, cottage cheese, or breakfast bars?
   _____ yes _____ no If yes, how often do you eat them?

   _____ daily _____3x week _____weekly No. of servings x 200_____
7. On average, how often do you eat a serving (3 oz.) of canned salmon or sardines (including bones)?
   _____ daily _____3x week _____ weekly _____ never No. of servings x 150_____
8. How many alcoholic beverages do you have in an average day?* (one alcoholic beverage equals: 5 oz. of wine, 12 oz. of beer; 1.5 oz. of hard liquor) Wine: _____ 1 _____ 2 _____ more Beer: _____1 _____2 _____ more
   Liquor: _____ 1 _____ 2 _____ more
9. What medications do you currently take?* _____

   _____
10. Do you take any multivitamin supplements? _____yes _____ no

    If yes, which one?_____ No. tabs/day _____ No. of tablets x mg/tab_____
11. Do you take a calcium supplement? _____ yes _____ no
    If yes, what type? _____ No. tabs/day _____ No. of tablets x mg/tab_____

*Certain medications and alcohol can reduce a patient's calcium level.

Compiled by Pat Baird, MA, RD, FADA