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

ARTHRITIS AND RHEUMATIC DISEASE ASSOCIATES, P.C.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ('HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures or my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do, then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: ____

OFFICE USE ONLY

Attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

____

Date: Initials: Reason:

____

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