PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION

(Please print)

Patient's Legal Name: (Last)_____ (First)_____ (MI) _____

Preferred Full Name (if different from above): _____

Home Phone Number (landline):_____ Cell:_____ Work: _____

Address: _____

City, State, Zip: _____

Email Address:_____ Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose ☐ Additional Gender Category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Choose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Swahili ☐ Portuguese ☐ Arabic ☐ Indian: Hindi, Tamil, Gujarati etc ☐ Russian ☐ Vietnamese ☐ Haitian ☐ Albanian ☐ Burmese ☐ Cambodian ☐ Creole Bosnian/Croatian/Serbian/Serbo-Croatian ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Other not listed_____

Patient Social Security Number:_____-_____-_____

RESPONSIBLE PARTY INFORMATION *(If not self)*

(Information used for patient balance statements)

Responsible Party: ☐ Another Patient ☐ Guarantor ☐ Self Check here is address and telephone information is same as patient ☐

Responsible Party Name: (Last)_____ (First)_____ (MI) _____

Date of Birth: MM____/ DD____/ YYYY_____ Sex: ☐ Female ☐ Male

Address: _____

City, State, Zip: _____

Responsible Party Social Security Number:_____-_____-_____ Phone Number:_____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: (Last)_____ (First)_____

Phone Number:_____ Do you have a living will: ☐ Yes ☐ No

Emergency contact relationship to patient: _____ ☐ Guardian

Address: _____

City, State, Zip: _____

Home Phone:_____ Work Phone:_____ Ext._____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date:_____

Printed name of patient or personal representative:_____ Relationship to patient: _____

PINNACLE MEDICAL GROUP

Rheumatology

Kenneth H. Crager, M.D., F.A.C.R.

PATIENT HISTORY AND PHYSICAL

Name:_____ Age:_____ Date: _____

Referring Physician:_____ Primary Physician: _____

ALLERGIES _____

PAST MEDICAL HISTORY:

Please check all that apply

❑ Heart Disease
❑ Heart Attack
❑ High Blood Pressure
❑ Diabetes
❑ Lung Disease
❑ Kidney Disease
❑ Peptic Ulcer Disease
❑ Stroke
❑ Thyroid Disease
❑ Peripheral Vascular
❑ Gout
❑ Joint Replacement(s): _____

❑ Kidney Stones
❑ Glaucoma
❑ Osteoporosis
❑ Gall Bladder Surgery
❑ Appendectomy
❑ Tonsillectomy
❑ Abdominal Surgery
❑ Hernia Surgery
❑ Sinusitis
❑ Miscarriage
❑ Other – Please list:

❑ Fractures(s): _____

FEMALE: Hysterectomy: ❑ Partial ❑ Complete Last Dexa/Bone Density:_____

MALE: Last PSA (Prostate Cancer Check): _____ Result_____

SURGICAL HISTORY:

Date	Procedure:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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PATIENT HISTORY AND PHYSICAL

Patient Name:_____ Date: _____

SOCIAL HISTORY:

Occupation (Past/Present): _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Children_____

Alcohol:	❑ Never	❑ Yes	If "Yes" _____ drinks per _____
Quit:	❑ No	❑ Yes	If "Yes" how many years?_____
Tobacco:	❑ Never	❑ Yes	If "Yes" packs per day? _____
Quit:	❑ No	❑ Yes	If "Yes" how many years?_____
Recreational Drugs:	❑ Never	❑ Yes	If "Yes" ❑ Oral ❑ IV
Quit:	❑ No	❑ Yes	If "Yes" how many years?_____
Coffee:	❑ Never	❑ Yes	If "Yes" cups per day? _____

FAMILY HISTORY:

Arthritis ❑ Rheumatoid _____ ❑ Osteo _____ ❑ Gout _____

❑ Cancer _____

❑ Osteoporosis _____ ❑ High Blood Pressure_____

❑ Heart Disease _____ ❑ Diabetes _____

❑ Stroke _____ ❑ Vasculitis _____

❑ Lupus _____ ❑ Scleroderma _____

❑ Polymyalgia Rheumatica _____ ❑ Sjogrens _____

CURRENT MEDICATION(S):

Name and Dose:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PINNACLE MEDICAL GROUP

Rheumatology

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PATIENT HISTORY AND PHYSICAL

Name: _____ DOB: _____

DO YOU EXPERIENCE:

Please check all that apply

- ❑ Non-restful sleep patterns
  - ❑ How many hours of sleep per night _____
  - ❑ Snoring
  - ❑ Awake short of breath
  - ❑ Cramping or jerking at night
- ❑ Fatigue
- ❑ Palpitations/irrigular heartbeat
- ❑ Fevers
- ❑ Chills
- ❑ Nausea
- ❑ Infections
- ❑ Vomiting
- ❑ Hair loss with bald spot
- ❑ Chest pain
- ❑ Chest pain with deep breathing
- ❑ Abdominal/stomach Pain
- ❑ Shortness of breath
- ❑ Rash/skin changes
- ❑ Diarrhea:
  ❑ Frequent ❑ Rare ❑ Diet related
- ❑ Burning with Irrination
- ❑ Oral ulcers
- ❑ Red/tender eyes
- ❑ Blue/white fingers and/or toes in cold weather temperatures
  Skin thickens ❑ Yes ❑ No
- ❑ Joint/Muscle stiffness in the morning
  lasting _____ hours _____ minutes
- ❑ Swelling joints
- ❑ Cough:
  ❑ Productive ❑ Dry
- ❑ Headaches:
  ❑ Frequent ❑ Rare
- ❑ Loss of vision
- ❑ Scalp tenderness
- ❑ Difficulty swallowing in:
  ❑ Throat ❑ Chest
- ❑ Weight Loss/Gain in the past 12 months
  How many pounds lost _____ gained_____
  Activity: ❑ Increased ❑ Decreased
  Appetite: ❑ Increased ❑ Decreased
- ❑ Seizures
- ❑ Dry Eyes
  Use artificial tears ❑ Yes ❑ No
- ❑ Dry mouth
  - ❑ Requires water to swallow food
  - ❑ Always have bottle of water
  - ❑ Dry foods stick to mouth
- ❑ Hallucinations
- ❑ Weakness in arms and/or legs
- ❑ Blood disorder
- ❑ Kidney disorder/frequent urinary tract infections
- ❑ Loss of sensation/numbness
- ❑ Indigestion/heartburn

American College of Rheumatology

PATIENT ASSESSMENT

Considering all the ways in which illness and health conditions may affect you at this time please make a mark below to show how you are doing:

Very Well ├──┤ **Very Poorly**

How much pain have you had because of your condition over the past week?
Place a mark on the line below to indicate how severe your pain has been:

No Pain ├──┤ **Pain as bad as it could be**

Pinnacle Medical Group

MEDICATIONS

Please include all prescription medication, vitamins and supplements, and any over the counter medication that you are currently taking.

Patient Name:_____ Date of Birth _____

Allergies: _____

MEDICATION NAME	STRENGTH	DOSE AND FREQUENCY