

PATIENT REGISTRATION FORM (eCW)

(Please print)

PATIENT INFORMATION

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 Rheumatology – Medical History Form

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**SOCIAL HISTORY:**

Do you smoke?  YES  NO If yes, how much per day? \_\_\_\_ If you quit smoking, when? \_\_\_\_\_

Do you drink alcohol?  YES  NO If yes, how often do you have a drink? \_\_\_\_\_

*PLEASE LIST ANY OF THE FOLLOWING THAT APPLY TO YOUR HEALTH (w/ dates if applicable):*

**MEDICAL PROBLEMS**

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**SURGERIES:**

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**FAMILY HISTORY:** *(please list whom disease/condition applies)*

Arthritis: \_\_\_\_\_

Autoimmune Disease: \_\_\_\_\_

Other: \_\_\_\_\_

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**CERTIFICATION**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

# PINNACLE MEDICAL GROUP

## Rheumatology

Brian T. McKinley, M.D.

315 75th Street West • Bradenton, FL 34209

941-792-8329

Physician Review

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

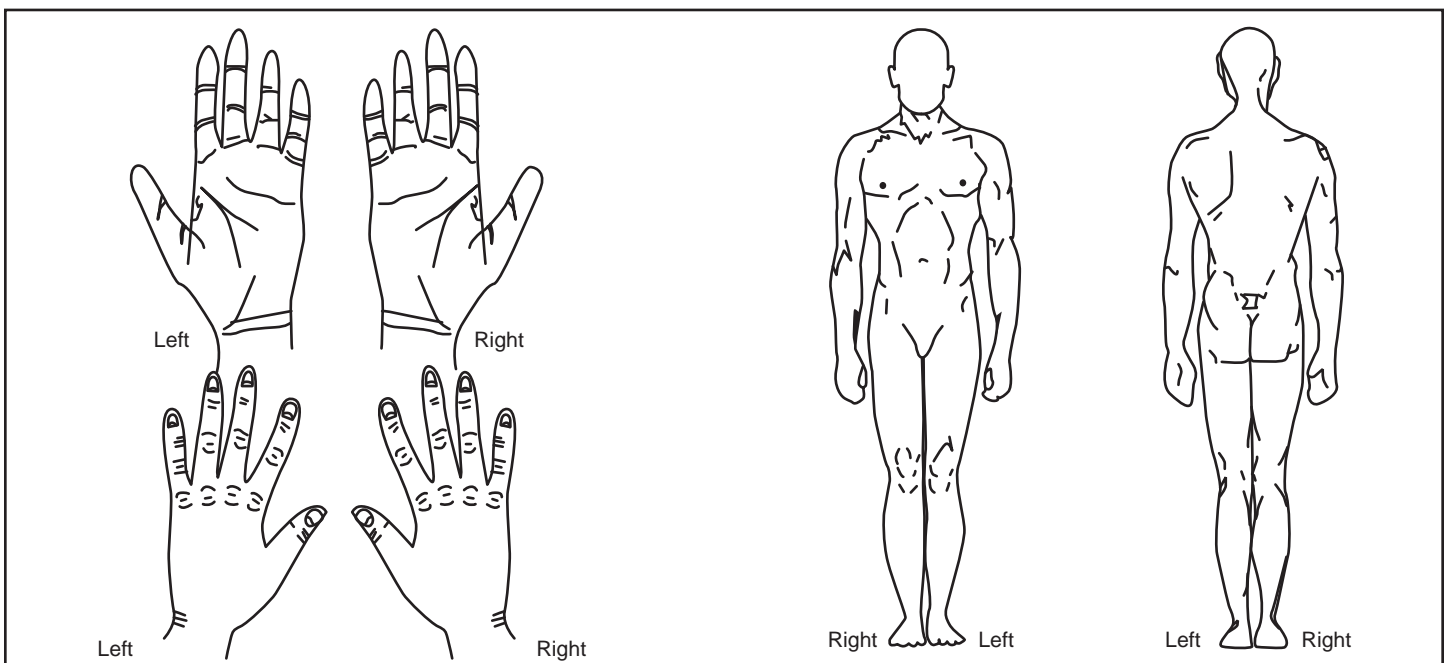
Please check the one best answer for your abilities. At this moment, you are able to:

	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	Unable to do
1. Dress yourself, including tying shoe laces & doing buttons?				
2. Get in and out of bed?				
3. Lift a full cup or glass to your mouth?				
4. Walk outdoors on flat ground?				
5. Wash and dry your entire body?				
6. Bend down to pick up clothing from the floor?				
7. Turn regular faucets on and off?				
8. Get in and out of a car, bus, train or airplane?				

1. When you get up in the morning, do you feel stiff?  Yes  No
2. If you answered "Yes", how long? \_\_\_\_\_ Min. or \_\_\_\_\_ Hrs.
3. Do you get enough sleep at night?  Yes  No
4. Do you wake feeling rested?  Yes  No
5. Rate your arthritis pain over the past week? Select a number below.

(No pain)    1   2   3   4   5   6   7   8   9   10    (Worst pain)

Below, please shade in all areas of the body and/or hands for which you have experienced discomfort over the past week:



# PATIENT HISTORY AND PHYSICAL

Physician Review

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## DO YOU EXPERIENCE:

Please check all that apply.

- Non-restful sleep
- Fatigue
- Fevers
- Recurrent infections
- Weight change over last year
  - Increase: \_\_\_\_\_ lbs.
  - Decrease: \_\_\_\_\_ lbs.
- Red/tender/dry eyes
- Dry mouth
- Oral ulcers
- Swollen lymph
- Chest pain
- Palpitations/irregular heartbeat
- Chest pain with deep breathing
- Cough:  Productive  Dry
- Nausea/vomiting/abdominal pain
- Indigestion/heatburn
- Difficulty swallowing:
  - Solids  Liquids
- Diarrhea:  Frequent  Rare
  - Diet related
- Constipation:
  - Frequent  Rare
- Headaches:
  - Frequent  Rare
- History of abrupt loss of vision
- Jaw pain when chewing
- Scalp tenderness
- Loss of sensation/numbness
  - Arm -  Right  Left
  - Leg -  Right  Left
- Weakness
  - Arm -  Right  Left
  - Leg -  Right  Left
  - All over
- Hallucinations
- Blackouts/seizures
- Rash/skin changes
- Blue/white skin color changes in the cold
  - Fingers
  - Toes
- Hair loss with bald spot
- Blood Disorder

