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 Rheumatology – Medical History Form

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

_____

_____

_____

_____

SURGERIES:

_____

_____

_____

_____

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

Arthritis: _____

Autoimmune Disease: _____

Other: _____

_____

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: _____

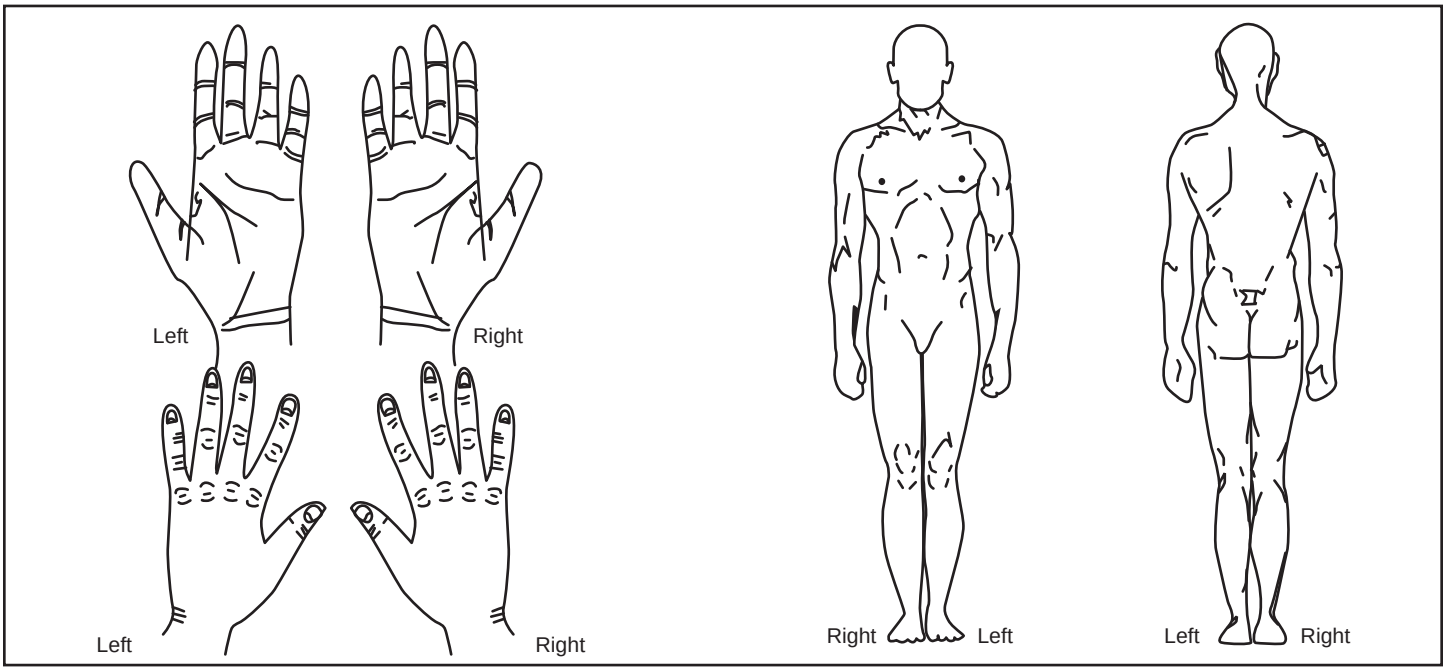
Please check the one best answer for your abilities. At this moment, you are able to:

	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

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