NEW PATIENT CHECKLIST

Please confirm you have:

_____ Completed New Patient History Form **(needs to be thorough)**

_____ Completed Patient Demographics Form

_____ Copy of Lab Work Report(s): to include

A. Within Last 12 months
B. **Any** Antibody testing done in the past

_____ Copy of Last 3 Office Notes **(from referring provider and/or primary care physician)**

_____ Copy of Imaging Reports **(within last 3 years)**

_____ Signed Credit Card Auth Form **(needed before scheduling new patient appointment)**

_____ Signed Office Policies Form

_____ Insurance Referral from PCP **(if insurance requires)**

*** To avoid delay on scheduling your New Patient Appointment all forms must be returned to the office completed, signed and dated.**

**** Forms cannot be faxed.**

Send information to: Mid-Atlantic Rheumatology
231 Najoles Road Suite 160
Millersville MD 21108

Questions: Please call 410-787-9400

New Patient Demographic

Patient Name: ______________________________ DOB: ____________
Address: ____
City: ______________________ State ______ Zip ____________
Phone: __________________ Cell phone: ____________________
E-Mail: ____
Sex: Male Female Other: ______________________________
Preferred Language: __________ Interpreter need? Yes No
Race: ______________________ Ethnicity: ____________________

Primary Care Provider: ____
Office Number: ________________ Fax Number: ________________
Address: ____
City: ______________________ State: ______ Zip: ____________
Pharmacy: ____________________ Phone #: ____________________
Address: ____________________ Fax #: ____________________

Referred By: __________________________ Relation: ____________

Complete below if Referred by Provider, other than PCP

Office Number: ____________________ Fax Number: ____________
Address: ____
City: State: Zip:

Emergency contact	***Relationship***	***Phone Number***

Primary Insurance: ____
Patient ID ______________________ Group ____________________
Claims address: ____
Provider phone number: ________________ Policy Holder:
Policy Holder DOB:

Secondary Insurance: ____
Patient ID: ______________________ Group#: ________________
Claims address: ____
Provider phone number: ________________ Policy Holder:
Policy Holder DOB:

Date Completed: ____________________

AMERICAN COLLEGE OF RHEUMATOLOGY

EDUCATION • TREATMENT • RESEARCH

Patient History Form

Date of first appointment: ____/____/____ (MONTH DAY YEAR) Time of appointment: __________ Birthplace: ____________________

Name: ____ (LAST FIRST MIDDLE INITIAL MAIDEN) Birthdate: ____/____/____ (MONTH DAY YEAR)

Address: ____ (STREET APT#) Age: __________ Sex: ❑ F ❑ M

____ (CITY STATE ZIP) Telephone: Home (____) __________

Work (____) __________

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses ____________________

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School ____________

Occupation ______________________ Number of hours worked/average per week ________

Referred here by: (check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: ______________________________

The name of the physician providing your primary medical care: ______________________________

Do you have an orthopedic surgeon? ❑ Yes ❑ No If yes, Name: ______________________________

Describe briefly your present symptoms: ______________________________

____

____

____

Date symptoms began (approximate): ______________

Diagnosis: ______________________________

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

____

____

____

Please list the names of other practitioners you have seen for this problem:

____

____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:

Example

LEFT RIGHT LEFT

LEFT RIGHT

Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

Patient's Name ______________________ Date ______________________ Physician Initials _______

Patient History Form © 1999 American College of Rheumatology

Review of Systems

Constitutional
- ❑ Chills
- ❑ Fatigue
- ❑ Fever
- ❑ Night sweats
- ❑ Recent weight gain amount ________
- ❑ Recent weight loss amount ________
- ❑ Weakness

Eyes
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears-Nose-Mouth-Throat
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Bleeding gums
- ❑ Bloody noses/epistaxis
- ❑ Loss of taste
- ❑ Cavities/dental caries
- ❑ Dryness of mouth
- ❑ Dryness of nose
- ❑ Difficulty swallowing/dysphagia
- ❑ Facial pain
- ❑ Hearing loss R___ L___
- ❑ Hoarseness
- ❑ Jaw pain
- ❑ Nasal Drainage
- ❑ Nasal ulcers/sores
- ❑ Oral ulcers/sores
- ❑ Sinusitis, recurrent
- ❑ Sore Throat
- ❑ Sore Tongue
- ❑ Ringing in ears/Tinnitus

Respiratory
- ❑ Apnea or snoring
- ❑ Cough
- ❑ Frequent Respiratory Infection
- ❑ Coughing up blood (hemoptysis)
- ❑ Shortness of breath when lying flat (Orthopnea)
- ❑ Chest wall pain on deep breath/cough (Pleurisy)
- ❑ Shortness of breath
- ❑ Wheezing (asthma)

Cardiovascular
- ❑ Chest Pain
- ❑ Leg pain with walking/claudication
- ❑ Leg swelling/edema
- ❑ Palpitations/Irregular heartbeat
- ❑ Color changes of hands/feet in the cold (Raynaud's)
- ❑ Tachycardia (fast heartbeat)
- ❑ Thrombophlebitis (inflammation of veins)
- ❑ Varicose veins
- ❑ Heart murmurs

Gastrointestinal
- ❑ Abdominal cramping
- ❑ Abdominal Pain
- ❑ Bloating
- ❑ Bloody/maroon/black color stool
- ❑ Constipation
- ❑ Diarrhea
- ❑ Early satiety (gets full easily when eating)
- ❑ Incontinence of Stool
- ❑ Heartburn (GERD, Reflux)
- ❑ Hemorrhoids
- ❑ Loss of appetite
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting of blood or coffee-ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice (Yellow eyes/skin)

Genitourinary
- ❑ Difficult urination (Trouble with flow)
- ❑ Pain or burning on urination (Dysuria)
- ❑ Genital lesions or Ulcers
- ❑ Blood in urine (Hematuria)
- ❑ Kidney stones
- ❑ Discolored or Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine (Nocturia)
- ❑ Pelvic pain
- ❑ Polyuria (Urinating a lot)
- ❑ Recurrent UTI
- ❑ Scrotum or Testicular Pain
- ❑ Urinary incontinence
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began: ________

Periods regular? ❑ Yes ❑ No

Date of last period?____/____/____

Bleeding after menopause? ❑ Yes ❑ No Number of pregnancies? ____________________ Number of miscarriages? ______________

Skin
- ❑ Acne
- ❑ Hives
- ❑ Itching
- ❑ Fingernail or Toenail changes
- ❑ Photosensitivity (rashes from the sun) (feel sick with sun exposure)
- ❑ Psoriasis
- ❑ Rash
- ❑ Tightness/thickening of the skin
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold
- ❑ Sores that don't heal
- ❑ Poor wound healing
- ❑ Eczema
- ❑ Foot or leg ulcers
- ❑ Blackened tissue

Patient's Name:______________________ Date:____________________ Physician Initials: ____________

Review of Systems

Musculoskeletal

- ☐ Morning stiffness
  Lasting how long?
  Minutes______Hours_________
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint Tenderness

List the joints involved over the last 6 months

____
____
____
____
____
____
____
____
____

- ☐ Muscle tenderness
- ☐ Height loss
- ☐ Thoracic Back Pain
- ☐ Neck Pain
- ☐ Neck stiffness
- ☐ Muscle cramping or spasms
- ☐ Myalgia or muscle achiness

Neurological System

- ☐ Confusion/disorientation
- ☐ Dizziness
- ☐ Extremity numbness
- ☐ Extremity weakness
- ☐ Gait disturbance (off balance, falling)
- ☐ Fainting or near fainting (Syncope)
- ☐ Headaches or migraines
- ☐ Seizures
- ☐ Tingling or numbness
- ☐ Tremors
- ☐ Numbness/pain of hands and/or feet
- ☐ Memory loss

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Easily losing temper
- ☐ Hallucinations (hearing voices or seeing things that are not there)
- ☐ Difficulty falling asleep (insomnia)
- ☐ Difficulty staying asleep (insomnia)
- ☐ Suicidal thoughts

Endocrine

- ☐ Excessive thirst
- ☐ Cold or heat intolerance
- ☐ Abnormal breast enlargement (gynecomastia)
- ☐ Growth of hair where it shouldn't grow (Hursutism)
- ☐ Hot Flashes or other menopausal symptoms
- ☐ Excessive sweating

Hematologic/Lymphatic

- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Swollen glands
  Neck_____ Armpits_____ Groin_____
- ☐ Tender glands
  Neck_____ Armpits_____ Groin_____
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when____________

Allergic/Immunologic

- ☐ Allergic Rhinitis
- ☐ Frequent infections
- ☐ Food allergies
- ☐ Gluten intolerance
- ☐ Seasonal allergies

Patient's Name ____________________ Date ____________________ Physician Initials __________

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? ____________________

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago? ________

Do you drink alcohol? ❑ Yes ❑ No Number per week ________

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No
If yes, please list: ____________________

____

Do you exercise regularly? ❑ Yes ❑ No

Type ____________________

Amount per week ____________________

How many hours of sleep do you get at night? ________

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

PAST MEDICAL HISTORY

Do you now or have you ever had: *(check if "yes")*

❑ Cancer	❑ Heart problems	❑ Asthma
❑ Goiter	❑ Leukemia	❑ Stroke
❑ Cataracts	❑ Diabetes	❑ Epilepsy
❑ Nervous breakdown	❑ Stomach ulcers	❑ Rheumatic fever
❑ Bad headaches	❑ Jaundice	❑ Colitis
❑ Kidney disease	❑ Pneumonia	❑ Psoriasis
❑ Anemia	❑ HIV/AIDS	❑ High Blood Pressure
❑ Emphysema	❑ Glaucoma	❑ Tuberculosis

Other significant illness (please list) ____________________

____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

____

____

____

Previous Operations

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes Describe: ____________________

Any other serious injuries? ❑ No ❑ Yes Describe: ____________________

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings ________ Number living ________ Number deceased ________

Number of children ________ Number living ________ Number deceased ________ List ages of each ________

Health of children: ____________________

____

Do you know of any blood relative who has or had: (check and give relationship)

❑ Cancer ________	❑ Heart disease ________	❑ Rheumatic fever ________	❑ Tuberculosis ________
❑ Leukemia ________	❑ High blood pressure ________	❑ Epilepsy ________	❑ Diabetes ________
❑ Stroke ________	❑ Bleeding tendency ________	❑ Asthma ________	❑ Goiter ________
❑ Colitis ________	❑ Alcoholism ________	❑ Psoriasis ________	

Patient's Name ____________________ Date ____________________ Physician Initials ________

Patient History Form © 1999 American College of Rheumatology

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? ______________________________

____

Type of reaction: ______________________________

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)		❑	❑	❑	
Codeine (Vicodin, Tylenol 3)		❑	❑	❑	
Propoxyphene (Darvon/Darvocet)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		❑	❑	❑	
Gold shots (Myochrysine or Solganol)		❑	❑	❑	
Hydroxychloroquine (Plaquenil)		❑	❑	❑	
Penicillamine (Cuprimine or Depen)		❑	❑	❑	
Methotrexate (Rheumatrex)		❑	❑	❑	
Azathioprine (Imuran)		❑	❑	❑	
Sulfasalazine (Azulfidine)		❑	❑	❑	
Quinacrine (Atabrine)		❑	❑	❑	
Cyclophosphamide (Cytoxan)		❑	❑	❑	
Cyclosporine A (Sandimmune or Neoral)		❑	❑	❑	
Etanercept (Enbrel)		❑	❑	❑	
Infliximab (Remicade)		❑	❑	❑	
Prosorba Column		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient's Name ______________________ Date ______________________ Physician Initials _______

Patient History Form © 1999 American College of Rheumatology

PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		❑	❑	❑	
Alendronate (Fosamax)		❑	❑	❑	
Etidronate (Didronel)		❑	❑	❑	
Raloxifene (Evista)		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal (Miacalcin, Calcimar)		❑	❑	❑	
Risedronate (Actonel)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid (Benemid)		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol (Zyloprim/Lopurin)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen (Nolvadex)		❑	❑	❑	
Tiludronate (Skelid)		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyalgan/Synvisc injections		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	
Please list supplements:					

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list: ______________________________

Patient's Name ____________________ Date ____________________ Physician Initials ________

Patient History Form © 1999 American College of Rheumatology

ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No If yes, how many? ______________________

How many people in household? ______________ Relationship and age of each ____

Who does most of the housework?__________ Who does most of the shopping? __________ Who does most of the yard work? __________

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from chair?	❑	❑	❑
Touching your feet while seated?	❑	❑	❑
Reaching behind your back?	❑	❑	❑
Reaching behind your head?	❑	❑	❑
Dressing yourself?	❑	❑	❑
Going to sleep?	❑	❑	❑
Staying asleep due to pain?	❑	❑	❑
Obtaining restful sleep?	❑	❑	❑
Bathing?	❑	❑	❑
Eating?	❑	❑	❑
Working?	❑	❑	❑
Getting along with family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness?	❑	❑	❑
Do you use a cane, crutches, as walker or a wheelchair? (circle one)	❑	❑	❑

What is the hardest thing for you to do?____

Are you receiving disability?............................ Yes ❑ No ❑

Are you applying for disability?............................ Yes ❑ No ❑

Do you have a medically related lawsuit pending?............................ Yes ❑ No ❑

Patient's Name ______________________ Date ______________________ Physician Initials ________

Patient History Form © 1999 American College of Rheumatology

Name: ______________________

Date: ______________

RAPID3

ROUTINE ASSESSMENT OF PATIENT INDEX DATA

The RAPID3 includes a subset of core variables found in the Multi-dimensional HAQ (MD-HAQ). Page 1 of the MD-HAQ, shown here, includes an assessment of physical function (section 1), a patient global assessment (PGA) for pain (section 2), and a PGA for global health (section 3). RAPID3 scores are quickly tallied by adding subsets of the MD-HAQ as follows:

1. PLEASE CHECK THE ONE BEST ANSWER FOR YOUR ABILITIES AT THIS TIME:

OVER THE LAST WEEK, WERE YOU ABLE TO:	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
a. Dress yourself, including tying shoelaces and doing buttons?	___ 0	___ 1	___ 2	___ 3
b. Get in and out of bed?	___ 0	___ 1	___ 2	___ 3
c. Lift a full cup or glass to your mouth?	___ 0	___ 1	___ 2	___ 3
d. Walk outdoors on flat ground?	___ 0	___ 1	___ 2	___ 3
e. Wash and dry your entire body?	___ 0	___ 1	___ 2	___ 3
f. Bend down to pick up clothing from the floor?	___ 0	___ 1	___ 2	___ 3
g. Turn regular faucets on and off?	___ 0	___ 1	___ 2	___ 3
h. Get in and out of a car, bus, train, or airplane?	___ 0	___ 1	___ 2	___ 3
i. Walk two miles or three kilometers, if you wish?	___ 0	___ 1	___ 2	___ 3
j. Participate in recreational activities and sports as you would like, if you wish?	___ 0	___ 1	___ 2	___ 3
k. Get a good night's sleep?	___ 0	___ 1.1	___ 2.2	___ 3.3
l. Deal with feelings of anxiety or being nervous?	___ 0	___ 1.1	___ 2.2	___ 3.3
m. Deal with feelings of depression or feeling blue?	___ 0	___ 1.1	___ 2.2	___ 3.3

1. a-j FN (0-10):

1=0.3	16=5.3
2=0.7	17=5.7
3=1.0	18=6.0
4=1.3	19=6.3
5=1.7	20=6.7
6=2.0	21=7.0
7=2.3	22=7.3
8=2.7	23=7.7
9=3.0	24=8.0
10=3.3	25=8.3
11=3.7	26=8.7
12=4.0	27=9.0
13=4.3	28=9.3
14=4.7	29=9.7
15=5.0	30=10

2. PN (0-10):

3. PTGE (0-10):

RAPID3 (0-30)

2. HOW MUCH PAIN HAVE YOU HAD BECAUSE OF YOUR CONDITION OVER THE PAST WEEK? PLEASE INDICATE BELOW HOW SEVERE YOUR PAIN HAS BEEN:

NO PAIN — PAIN AS BAD AS IT COULD BE

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

3. CONSIDERING ALL THE WAYS IN WHICH ILLNESS AND HEALTH CONDITIONS MAY AFFECT YOU AT THIS TIME, PLEASE INDICATE BELOW HOW YOU ARE DOING:

VERY WELL — VERY POORLY

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

CONVERSION TABLE

Near Remission (NR): 1=0.3; 2=0.7; 3=1.0
Low Severity (LS): 4=1.3; 5=1.7; 6=2.0
Moderate Severity (MS): 7=2.3; 8=2.7; 9=3.0; 10=3.3; 11=3.7; 12=4.0
High Severity (HS): 13=4.3; 14=4.7; 15=5.0; 16=5.3; 17=5.7; 18=6.0; 19=6.3; 20=6.7; 21=7.0; 22=7.3; 23=7.7; 24=8.0; 25=8.3; 26=8.7; 27=9.0; 28=9.3; 29=9.7; 30=10.0

HOW TO CALCULATE RAPID 3 SCORES

1. Ask the patient to complete questions 1, 2, and 3 while in the waiting room prior to his/her visit.
2. For question 1, add up the scores in questions A-J only (questions K-M have been found to be informative, but are not scored formally). Use the formula in the box on the right to calculate the formal score (0-10). For example, a patient whose answers total 19 would score a 6.3. Enter this score as an evaluation of the patient's functional status (FN).
3. For question 2, enter the raw score (0-10) in the box on the right as an evaluation of the patient's pain tolerance (PN).
4. For question 3, enter the raw score (0-10) in the box on the right as an evaluation of the patient's global estimate (PTGE).
5. Add the total score (0-30) from questions 1, 2, and 3 and enter them as the patient's RAPID 3 cumulative score. Use the final conversion table to simplify the patient's weighed RAPID 3 score. For example, a patient who scores 11 on the cumulative RAPID 3 scale would score a weighed 3.7. A patient who scores between 0–1.0 is defined as near remission (NR); 1.3–2.0 as low severity (LS); 2.3–4.0 as moderate severity (MS); and 4.3–10.0 as high severity (HS).

Vaccine, Advanced Directives, and Emergency Contact Form

Name:__________________ Date of Birth:____________ Date of Visit:__________

Question	Circle yes or no		Approximate date
Have you gotten a flu shot since August 2022?	Yes	No	
Have you had a Prevnar-13 pneumonia shot?	Yes	No	
Have you had the Pneumovax also called the PPV-23 pneumonia vaccine?	Yes	No	
Have you completed the Shingrix vaccine series?	Yes	No	
Do you have a living will or advanced directives?	Yes	No	N/A
Who is your emergency contact?	Name_________________ Relation_______________		Phone Number ___________________
Do you want to list your emergency contact on your HIPAA form?	Yes	No	N/A
Have you received the Covid-19 Vaccine? Type: Pfizer/ Moderna/ J&J	Yes	No	1st Dose: / / 2nd Dose: / / 3rd Dose: / /
Have you had a Dexa scan done?	Yes	No	
Have you had TB test recently?	Yes	No	

Mid-Atlantic Rheumatology
Dr. Erinn Maury, Dr. Hesum Chegini, Hope Pennestri CRNP
231 Najoles Rd Suite 160
Millersville, MD 21108
Phone: (410)787-9400 Fax: (410)787-9405

Welcome to the Practice! We apologize for the wait but please know that when it comes to your new patient appointment you will receive the time and attention that you need. I would like to remind you of a few directions that were reviewed with you at the time you scheduled. I know that you received a lot of information and I find that it helps to see it in writing!

When you arrive for your appointment, please remember to bring a **referral** from one of your physicians. I know that your insurance does not always require one, but we do. I would like to know from that physician why they sent you to see Rheumatology. We also require you to **arrive 30 minutes prior** to your **appointment** time with a **state issue ID as well as your insurance card(s)**. We need time to process this information, review your forms and have you complete some more. If you fail to arrive 30 minutes before the appointment, we may need to reschedule your appointment.

You are receiving a new patient history form. You are also receiving an enrollment token for our Patient Portal. Our preference is to use the portal. If you have done so, it is not necessary to complete the form. One or other MUST be completed prior to your scheduled appointment.

You also secured your new patient appointment with a credit card ending with_______ the expires on ______/______. At that time, you were informed of our cancellation policy that requires at least **24-hour cancellation notice**. If you **fail to give us the required notice** and/or do not show up for your appointment there will be a $250.00 charge made to your credit card. We require your signature on this form to confirm that you agree to this policy. This form must be returned to our office within the next 2 weeks, or your appointment MAY be cancelled. You may either drop it by our office, fax it to us or send it by mail.

If you have any further questions, feel free to call my staff during regular business hours. They are Mondays and Thursdays 9:00-5:00, Tuesdays 10:00-6:00, Friday 9:00-2:00.

We look forward to seeing you at your appointment!

Your signature below means that you agree to terms stated above

X____

Authorization for the Release of Medical Information

By signing this form, I either wish to file a complaint, or I authorize a health care provider to file a complaint on my behalf, with the Health Education and Advocacy Unit (HEAU) of the Office of the Attorney General and/or the Maryland Insurance Administration (MIA).

I authorize the HEAU and/or the MIA to contact my health care providers, my insurance carrier, HMO, and other State or Federal government agencies, to obtain any medical records, mental health or substance abuse records, and/or insurance information related to the complaint filed by me or on my behalf. I authorize my health care providers and insurance carriers to release any medical records, mental health or substance abuse records, and/or insurance information relevant to the complaint filed by me or on my behalf to the HEAU and/or the MIA. I understand that my treatment, payment, enrollment, or eligibility for benefits under my health plan may not be conditioned upon whether I sign this Authorization. However, I understand that the HEAU and MIA will be unable to process my complaint if I fail to sign this Authorization.

I authorize the HEAU and/or the MIA to release or redisclose my medical record and other information related to my complaint to my health care providers, my insurance carrier, HMO, and other State or Federal government agencies that may assist in the resolution of my complaint. I authorize the HEAU to assist me by mediating my complaint, filing a grievance or appeal with my insurance carrier, or by filing a complaint with the MIA or other State or Federal government agencies that may assist in the resolution of my complaint.

If my complaint is referred to or filed with MIA, I authorize MIA to release my medical records to health care providers, my insurance carrier, HMO, independent review organizations, medical experts and other government agencies or contractors that may assist in the resolution of my complaint.

There is the potential for information provided to be subject to redisclosure in the process of investigating the complaint and pursuing any action required as a result of the complaint investigation, in which case the information may no longer receive privacy protection under Federal law. I understand that information about my experience may be used to develop statistical information on the health care marketplace in Maryland or to examine the quality of care of an HMO, but the confidentiality of my identity and medical records will be protected in accordance with Maryland and Federal law.

This authorization is valid for one year. It shall be automatically revoked once the complaint has been resolved. I understand that I may revoke this Authorization at any time by notifying the Health Education and Advocacy Unit or the Maryland Insurance Administration, if my complaint has been referred to or filed with MIA, which will provide me with a form to sign confirming my revocation. A copy of the revocation will be provided to each party to whom this Authorization was provided. I understand that the revocation will not apply to the extent that a health care provider and/or insurance carrier has taken action in reliance on this authorization.

______________________________ ______________________________
Signature Date

____
Relationship: If the person signing this release is not the patient, please give the relationship to the patient.

______________________________ ______________________________
Patient Name Patient's Date of Birth

____
Patient's Health Insurance Membership #

PLEASE NOTE: All patients 18 years of age and over must sign this consent form themselves, unless they have a legal guardian, personal representative, are incapacitated or have otherwise delegated authority to complete this form. If so, the signer must submit written proof of guardianship, representation, incapacity or other delegation of authority with this consent form. A parent or guardian must sign on behalf of an unemancipated minor, except in certain circumstances. Where Maryland law allows a person under 18 to consent to health care treatment without the consent of a parent or guardian, only the signature of the patient is necessary.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:________________________________ **Date of Birth:**____________________________

Phone: H) ________________________________ **Phone: W)** ________________________________

Address: ________________________________ **City/State/Zip:** ________________________________

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: ________________________________ **Facility Phone:** ____________________

Facility Address:________________________________ **Facility Fax:**____________________

City, ST, Zip: ________________________________

Dates and Type of information to disclose:

- ☐ 2 years prior from last date seen
- ☐ Dates Other: ________________________________
- ☐ Specific Information Requested:

____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care (e.g., VA Med Ctr)
- ☐ Referral
- ☐ Other________________________________

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Mid-Atlantic Rheumatology, LLC

Address: 231 Najoles Road, Suite 160

City, State, Zip: Millersville, MD 21108-2659

Fax: 410-787-9405 **Phone:** 410-787-9400

☐ **Please mail records.**

☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X________________________________ ____________________

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

________________________________ ____________________

Printed name of Authorized Representative

Relationship / Capacity to patient

____

Address and telephone number of authorized representative

HIPAA
PATIENT CONSENT FORM
FOR THE USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

I hereby give consent to Erinn Maury, M.D. and all employees furnishing care within this office, to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have been given a copy of this to review before you sign this consent. We reserve the right to change the terms of our Notice. You may obtain a copy of the current notice at any time just by asking for one.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. You may deliver your revocation by any means you choose (e.g., personally or my mail), but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Print Patient Name: ________________________ Date: ___________________________
Sign: ____________________________________

If you are signing as the patient's representative:
Print your name: ___________________________
Authority: ________________________________

Names of whom you authorize us to give information to:
1. ______________________________ Relation: ______________________________
2. ______________________________ Relation: ______________________________
3. ______________________________ Relation: ______________________________

REVOCATION

I hereby revoke the consent given above.

Print Patient Name: ________________________ Date: ___________________________
Sign: ____________________________________

If you are signing as the patient's representative:
Print your name: ___________________________
Authority: ________________________________

YOUR REVOCATION WILL BE EFFECTIVE ONCE IT IS RECEIVED.

DATE RECEIVED: ________________________

Consent to Treat

Being at least 18 years of age and of sound mind, I, **Patient / Guardian**, the undersigned patient/responsible party have been informed of the treatment considered necessary for **myself / legal guardian** and any extension of this treatment or procedure, whether or not currently anticipated, that the attending physician may consider necessary during the course of such procedure in order to correct an immediate medical problem, and that such treatment and procedures (i.e. Labs, Vaccinations) will be performed by physicians who are staff members of **Mid-Atlantic Rheumatology**. The undersigned hereby consents and grants authorization for such treatment and procedures and certifies that no guarantee or assurance has been made as to the results that may be obtained. (The undersigned further consents to the disposal in accordance with applicable laws of body tissue or body parts that may be removed during the course of the procedure.)

The undersigned agrees to pay for the service rendered by **Mid-Atlantic Rheumatology** on the release of the patient.

I do hereby assign any hospital benefits of a liability of and payable by any third party for the herein-named patient to **Mid-Atlantic Rheumatology** unless I pay the amount in full on the release of the patient.

I do authorize Health Information Services of **Mid-Atlantic Rheumatology** to release any information requested by my insurance company(s) or other third-party payers in connection with this assignment. I do hereby appoint the Financial Manager of **Mid-Atlantic Rheumatology** as my lawful attorney to endorse for me any checks payable to me for debts or claims collected under this assignment and to apply any credit balance to any other debt I may owe to **Mid-Atlantic Rheumatology**.

Statement of Financial Responsibility

All services rendered are the payment responsibility of the patient. As a courtesy, we will bill your insurance carrier. The patient is responsible for all fees, regardless of insurance coverage or the usual and customary fees provided by your insurance company. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I will be responsible for any costs incurred as the result of my account having to be turned over to a collection agency or attorney.

I understand the full importance of this declaration.

____ _______________________________

Signature Date

____

Printed Name