ARTHRITIS & RHEUMATOLOGY OF GA, PC

GARY MYERSON, MD
ANNA ADAMS, PA-C
PAUL SUTEJ, MD
CASHELLE ROSE, PA-C
PAULA TANASA, MD
BRIGITTE COUNCIL, PA-C

NEW PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:	Social Security no.:	Home phone no.: ( )				
P.O. Box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.: ( )				
Referred to clinic by (please check one box):	❑ Dr. _____	❑ Insurance Plan	❑ Hospital			

INSURANCE INFORMATION

(Please give your insurance card to every visit)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance ❑ BCBS	❑ UHC	❑ Aetna	❑ [Insurance]	❑ [Insurance]	
❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ Medicare	❑ Other	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Authorization to Treat: I consent to examination, treatment and procedures which may be performed during my office visits including emergency treatment considered necessary by the physician and/or his designated provider. **Assignment of Insurance:** I hereby assign payment directly to Arthritis and Rheumatology of GA, P.C. for services covered by insurance or other health benefit plans. **Authorization for Release of Information:** I authorize ARG to release to my insurance carrier and its designated agents any medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS, necessary to process any healthcare related review or quality assurance activities. I also authorize the release of medical information to other healthcare providers who provide consultative services regarding my healthcare. This authorization remains in effect until revoked by me in writing. I agree that a photocopy of the same is as valid as the original.

Patient/Guardian signature *Date*

Patient Contacts

I/We authorize this medical practice to leave messages or discuss my PHI with the names listed below: (Include name and relationship)

_____Phone: _____

_____Phone: _____

Primary Care Physician: _____Phone:_____

Referring Physician: _____Phone:_____

Additional Physician: _____Phone:_____

Additional Physician: _____Phone:_____

Privacy Policies and Office Policies

I agree to the Privacy Policies (HIPPA) and Office Policies of Arthritis and Rheumatology of GA. I understand that a full copy of both the Privacy Practices and Office Policies are available to me at the office and at our website www.argmd.net.

Patient Signature: _____ Date: _____

	Retail Pharmacy	Specialty Pharmacy
Pharmacy Name		
Phone Number and Fax		
Address		
Store Number		
Email Address		

ARG Prescription Policy:

Medications prescribed by Arthritis and Rheumatology of GA, P.C. must be taken only in accordance with the instructions and dosage as prescribed by your physician. Only designated annual patients will receive a full one year refill amount of their medication. Otherwise, medication refills are given at each office visit.

If your medication requires a prior authorization, your pharmacy must contact our office. The prior authorization process can require up to two weeks to complete. You may always choose to pay by cash while you are waiting for the medication to be approved. Multiple calls to our office will not speed up this process, but we understand the frustration this often places on many of our patients.

Please understand that our office is open Monday – Thursday, each week from 7:00 am until 4:00 pm, and Closed on Friday. Our physicians will no longer call in refills after hours, over the weekend, or planned holidays. **Emergency after hour calls are NOT intended for refill requests.** Please plan accordingly.

Patient Signature: _____ Date: _____

Patient Questionnaire:

Please check all involved; complete to the best of your ability.

☐ Red Measles	☐ Liver Disease	☐ Skin Disease
☐ COPD	☐ Chickenpox	☐ Pneumonia
☐ High Blood Pressure	☐ Diabetes	☐ Kidney/Urinary problems
☐ German Measles	☐ Neurologic Disorders	☐ Arthritis
☐ Tuberculosis	☐ Polio Cancer	☐ Asthma
☐ Gastrointestinal Problems	☐ Emotional Disorders	☐ Heart Disease
☐ Mumps	☐ Rheumatic Fever	☐ Connective Tissue Diseases
☐ Thyroid Disease	☐ Blood Disorders	

Comments: (Year, complications, other):_____

_____

Immunizations (Approximate date if known):

Small Pox: ___/____/_____ Hepatitis B: ___/____/_____ Polio: ___/____/_____

German Measles: ___/____/____ Tetanus Booster: ___/____/____ Pneumonia: ___/____/_____

Mumps: ___/____/_____ Flu: ___/_____/_____ Other (Specify): ___/____/_____

PPD: ___/____/_____

Risk Factors:

Sun Exposure: ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Remote

Seatbelt usage: ☐ 100% ☐ 75% ☐ 50% ☐ 0%

Cigarettes: _____/day Cigars: _____/day Pipe(s):_____/day

Alcohol: _____/day Caffeine Intake (coffee, tea, cola, Etc.):_____/day

Drugs (Marijuana, other):_____

How often do you exercise per week? _____Types of exercise_____

Family History/Illness:

List age, state of health, (if deceased, include cause of death):

Father: _____ Mother: _____

Sibling(s): _____

Children (Male/Female) _____

Please Note the Relationship (Mother, Father, Etc.):

Diabetes_____ Migraine_____

High Blood Pressure_____ Psoriasis_____

Heart Disease_____ Tuberculosis_____

Kidney Disease_____ Arthritis_____

Stroke_____ Venereal Disease _____

Cancer_____ Double Jointed _____

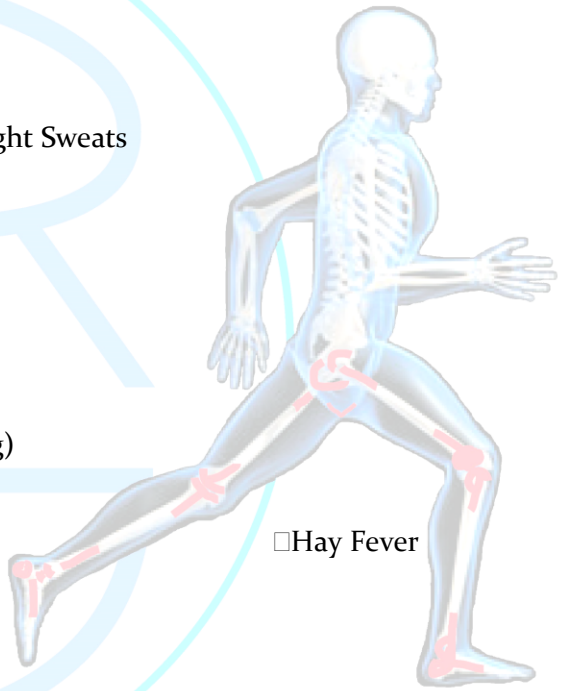
Asthma_____ Hardening of the Arteries _____

Thyroid Disease_____ Connective Tissue Disease _____

Review of Symptoms (Please check all that apply):

General:

□ Weakness □ Fever □ Chills □ Night Sweats
□ Fatigue: ___Morning / ___ Afternoon / ___Evening
□ Weight Changes: ___ More / ___ Less
□ Appetite Changes: ___ More / ___ Less



Eyes, Ears, Nose, Throat (EENT):

Ears:
□ Difficulty hearing □ Tinnitus (ringing)

Nose:
□ Bleeding □ Running □ Post nasal drip □Hay Fever
□ Stuffiness □ Sneezing □ Sinus trouble

Throat:
□ Sore throat □ Hoarseness □ Dry mouth
□ Throat pain □ Dental trouble □ Bleeding gum

Respiratory:

Shortness of Breath: □ At Rest / □ At Exertion

Cough:

□ Dry □ Wet □ Pleurisy □ Wheezing
□ Bloody □ Chest Pain □ Asthma

Cardiovascular:

Chest Pain: □ Tightness □ Squeezing □ Pressure □ Shortness of breath lying down □ Need to sit up to breathe

Heart: □ Murmur □ Pericarditis □ Irregular: ___Racing / ___Palpitations

Legs: □ Varicose Veins □ Pain at rest □ Pain with exertion

Color Change: ___Blue/___Red/ ___White

Breasts:

□ Fibrocystic Disease □ Lumps □ Pain □ Discharge

Gastrointestinal:

□ Nausea
□ Vomiting
□ Heartburn
□ Food intolerance
□ Need for antacids/PPI's
□ Gastritis
□ GERD
□ Ulcers
□ Diarrhea
□ Constipation
□ Change in bowel habit
□ Abdominal pain
□ Diverticular disease
□ Blood in stools
□ Hemorrhoids
□ Colitis

Urinary:

□ Burning
□ Urgency
□ Urinary tract infections
□ Difficulty starting /stopping
□ Discharge
□ Kidney stones
□ Interstitial cystitis
□ Frequency: ___Day / ___Night

Genito-Reproductive (Male):

□ History of venereal disease
□ Discharge from penis
□ Rash on penis
□ Testicular pain/lump
□ Decrease in testicular size
□ Decrease in sexual desire
□ Decreased ability to achieve erection

Genito-Reproductive (Female):

Menstrual Period Flow**:** □ Heavy □ Normal □ Light

Bleeding between cycle**:** _____ Age of onset: _____

Days between Period: _____ Duration: _____

Date of your last normal period**:** _____/_____/_____

Menopause onset:_____

□ Hot flashes
□ Hormone Replacement Therapy
□ Abnormal Vaginal Discharge
□ History of Venereal Disease
□ Genital Ulcers
□ Pain during intercourse

Obstetrical: Please indicate the number for the following:

_____Pregnancies _____ Full Term _____ Premature _____ Miscarriages _____ Stillborn

(check all that apply)

Complications: □ Preeclampsia □ Toxemia □ Severe hemorrhage

□ Other(s): _____

Endocrine:

Thyroid Gland:

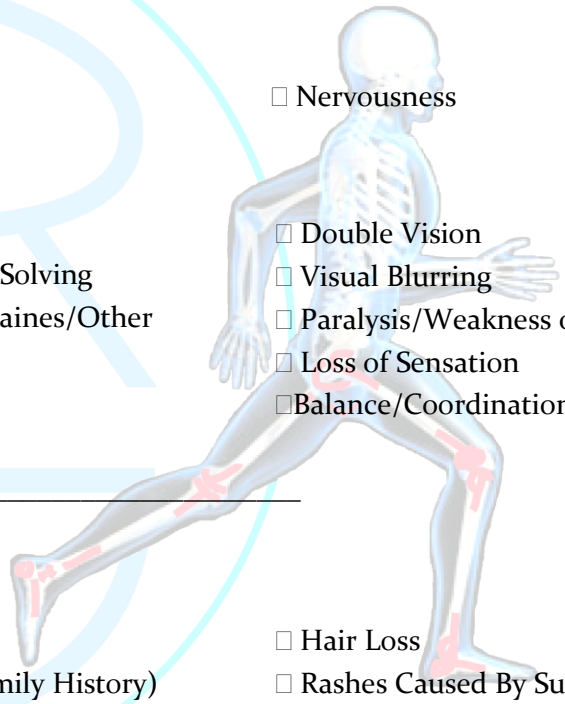
□ Goiter
□ Hyperthyroidism (overactive)
□ Change in body hair (face, underarms, or pubic)
□ Hypothyroidism (underactive)
□ Hashimotos Thyroiditis
□ Diabetes Type I or II
□ Increased thirst
□ Heat/Cold intolerance

Neurologic/Psychiatric:

□ Anxiety
□ Depression
□ Nervousness

Sleep Difficulty

□ Falling Asleep
□ Frequent Awakening
□Early morning awakening
□Difficulty with memory (Past/Present)
□ Tingling/Numbness/Burning (Location):_____
□Difficulty with thinking/Problem Solving
□ Headaches/Migraines/Other
□ Blackouts
□ Dizziness
□ Double Vision
□ Visual Blurring
□ Paralysis/Weakness of Limb
□ Loss of Sensation
□Balance/Coordination Problem



Skin:

□ Dryness
□ Itching
□ Rash
□ Hives
□ Welts
□ Eczema
□ Psoriasis (Or Family History)
□ Dandruff
□ Nail Changes
□ Change in Texture of the Hair
□ Hair Loss
□ Rashes Caused By Sunlight
□ Change in Skin Color
□ Skin Ulcers
□ Change of Finger Color in the Cold: ___Blue / ___White / ___Red

Musculoskeletal:

Extremities:

□ Heat
□ Redness
□ Swelling
□ Pain
□ Stiffness
□ Deformities
□ Double Jointed
□ Scoliosis/Kyphosis
□ Muscle pain/weakness
□ Bursitis
□ Tendonitis

Spine (Neck, Mid and Lower Back): □ Heat □ Redness □ Swelling □ Pain □ Stiffness

□ Morning stiffness (how many minutes to improve and location): _____

Does the change in weather cause stiffness? _____

Bones:

Previous Fractures: please indicate what area/and year: _____

_____

DXA Scans (Bone Density) and date: _____

_____

Previous Arthroplasty- (Joint Replacement): □ yes □ no

Please indicate the Body Prosthesis (Body Joint) - location and year:

_____

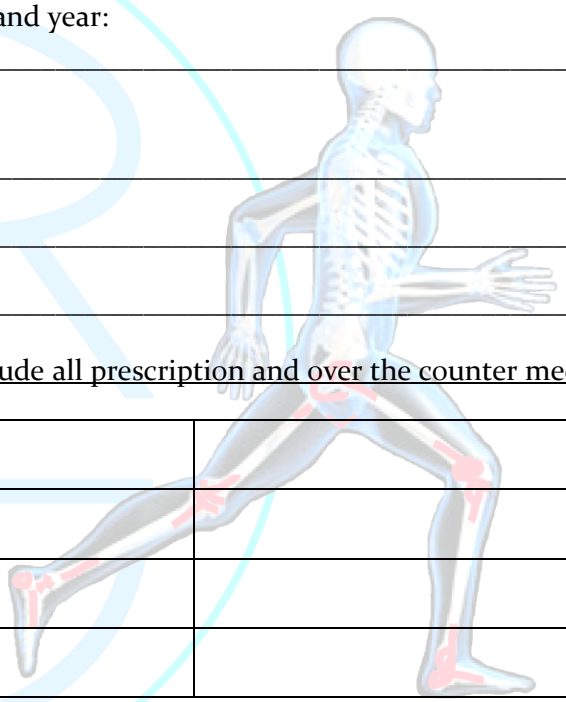
Please list previous surgeries:

_____

_____

_____

<u>PLEASE LIST ALL CURRENT MEDICATIONS TAKEN: Include all prescription and over the counter medicines.</u>



Medication / Food ALLERGIES and Symptoms:

_____

_____

Completed By: _____DATE:_____

Arthritis and Rheumatology of Ga. P.C.
Dr. Gary Myerson ~ Dr. Paul Sutej ~ Dr. Paula Tanasa

Past Medication Failure/Usage

Please check all that applies. Indicate any side effects or adverse events

NSAIDs: non-steroidal anti-inflammatory drugs

- ◯ Celebrex (Celecoxib)
- ◯ Voltaren (Diclofenac)
- ◯ Arthrotec (Diclofenac with misoprostol)
- ◯ Lodine (Etodolac)
- ◯ Nalfon (Fenoprofen)
- ◯ Ansaid (Flurbiprofen)
- ◯ Ibuprofen (Advil, Motrin)
- ◯ Indocin (Indomethacin)
- ◯ Ketoprofen (Actron, Orudis, Oruvail)
- ◯ Mobic (Meloxicam)
- ◯ Relafen (Nabumetone)
- ◯ Naproxen (Naprosyn, Naprelan, Aleve)
- ◯ Daypro (Oxaprozin)
- ◯ Feldene (Piroxicam)
- ◯ Salsalate (Salsitab)
- ◯ Sulindac (Clinoril)

DMARDs

- ◯ Hydroxychloroquine (Plaquenil)
- ◯ Leflunomide (Arava)
- ◯ Cyclosporine (Neoral)
- ◯ Sulfasalzine (Azulfidine)
- ◯ Methotrexate (Rheumatrex, Trexall)
- ◯ Azathioprine (Imuran)
- ◯ Cyclophosphamide (Cytoxan)
- ◯ Cimzia/Enbrel/Humira/Kineret /Simponi
- ◯ Actemra/Remicade/Rituxan/Orencia IV

Anti-depression/Fibromyalgia/Anxiety

- ◯ Adapin (doxepin)
- ◯ Celexa (citalopram)
- ◯ Cymbalta (duloxetine)
- ◯ Effexor XR (venlafaxine)
- ◯ Elavil (amitriptyline)
- ◯ Lexapro (escitalopram)
- ◯ Paxil (paroxetine)
- ◯ Prozac (fluoxetine)
- ◯ Pristiq (desvenlafaxine)
- ◯ Viibryd (vilazodone)
- ◯ Wellbutrin (bupropion)
- ◯ Zoloft (sertraline)

Sleeping aid/Anxiety

- ◯ Ambien (Zolpidem)
- ◯ Oleptro (trazodone)
- ◯ Sonata (Zaleplon)
- ◯ Lunesta (Eszopiclone)
- ◯ Dalmane (Flurazepam)
- ◯ Restoril (Temazepam)
- ◯ Remeron (mirtazapine)

Neurological/Fibromyalgia

- ◯ Lyrica (pregabalin)
- ◯ Neurontin (Gabapentin)

Acid reflux/GERD

- ◯ Aciphex (rabeprazole)
- ◯ Dexilant (dexlansoprazole)
- ◯ Kapidex (dexlansoprazole)
- ◯ Nexium (esomeprazole)
- ◯ Pepcid(famotidine)
- ◯ Prevacid (lansoprazole)
- ◯ Prilosec (omeprazole)
- ◯ Protonix (pantoprazole)
- ◯ Tagamet (cimetidine)
- ◯ Zantac (ranitidine)

Osteoporosis

- ◯ Actonel Oral (Risedronate)
- ◯ Atelvia Oral (Risedronate)
- ◯ Boniva Oral or IV (Ibandronate)
- ◯ Evista Oral (Raloxifene)
- ◯ Forteo SubQ (Teriparatide)
- ◯ Fosamax Oral (Alendronate)
- ◯ Prolia Inj (Denosumab)
- ◯ Reclast IV (Zoledronic acid)

Muscle relaxants

- ◯ Flexeril (Cyclobenzaprine)
- ◯ Soma (Carisoprodol)
- ◯ Zanaflex (Tizanadine)
- ◯ Skelaxin (Metaxalone)

OTHER

ARTHRITIS AND RHEUMATOLOGY OF GA, PC
980 JOHNSON FERRY RD NE, STE 220
ATLANTA, GA 30342
PHONE: 404.255.5956 FAX: 404.528.1858

Directions to Northside Hospital Doctors Centre:

Directions Traveling East on I-285

Exit #26 at the Glenridge Connector and turn right at the foot onto Glenridge Drive.
Merge into the left hand turn lane, and turn left at the light onto Johnson Ferry Road.
The Doctors Centre is on your left after crossing the bridge and before the next intersection.
Turn left into the Doctors Centre, the 960 Building is on the left and the 980 Building is on your right.
Parking is immediately ahead in the garage. The current cost to park is $6.00.

Directions Traveling West on I-285

Exit #28 at Peachtree-Dunwoody Road and turn left onto Peachtree Dunwoody Road.
Turn right at the fourth traffic light onto Johnson Ferry Road, in front of Northside Hospital.
Pass Northside Hospital on the right, Scottish Rite on your left.
The Doctors Centre is on your right, passing through the next traffic light.
Turn right into the Doctors Centre and drive straight ahead for the parking garage.
The 980 Building is on your right as your drive in. The current cost to park is $6.00.

Directions from GA 400 (North and South)

Traveling North take exit 4A and turn left onto the Glenridge Connector.
Turn right at the light onto Johnson Ferry Road.
The Doctors Centre is on your left before the Hospital.
Traveling South- Take exit #3 and turn left onto the Glenridge Connector.
Turn right at the light onto Johnson Ferry Road and the Doctors Centre is ahead on your immediate left. The parking deck is immediately ahead in the garage and the current cost to park is $6.00.

***Please be aware it is $6.00 **cash, check, or card** to park within the parking deck. This is regulated by a third party and not under our control. Thank you for your understanding. ***