

ARTHRITIS & RHEUMATOLOGY OF GA, PC

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NEW PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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):				<input type="checkbox"/> Dr. _____		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance <input type="checkbox"/> BCBS <input type="checkbox"/> UHC <input type="checkbox"/> Aetna <input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> Medicare <input type="checkbox"/> Other							
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /	Group no.:		Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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.: ()
<p>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.</p>			
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>

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

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 _____

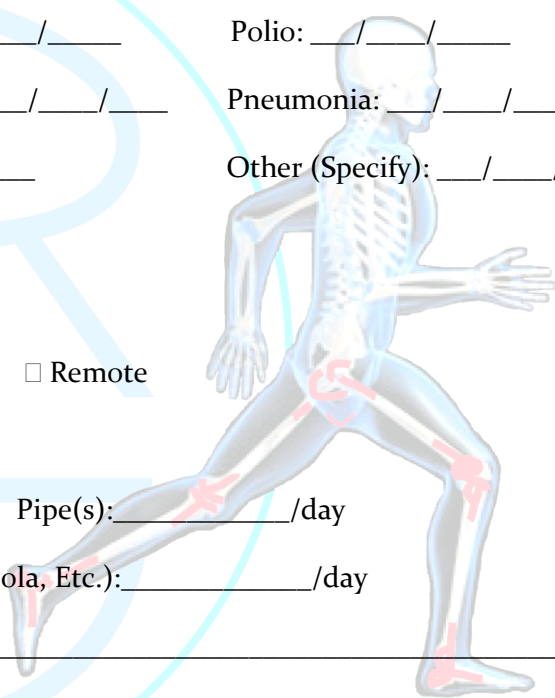
Family History/Illness:

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 _____

High Blood Pressure _____

Heart Disease _____

Kidney Disease _____

Stroke _____

Cancer _____

Asthma _____

Thyroid Disease _____

Migraine _____

Psoriasis _____

Tuberculosis _____

Arthritis _____

Venereal Disease _____

Double Jointed _____

Hardening of the Arteries _____

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
- Stiffness Sneezing Sinus trouble

Throat:

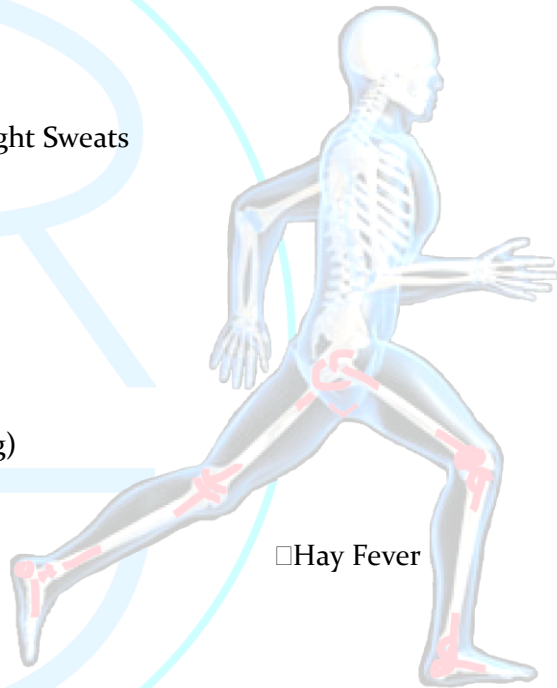
- Sore throat Hoarseness Dry mouth
- Throat pain Dental trouble Bleeding gum

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

Urinary:

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

Genito-Reproductive (Male):

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

Genito-Reproductive (Female):

Menstrual Period Flow: Heavy Normal Light

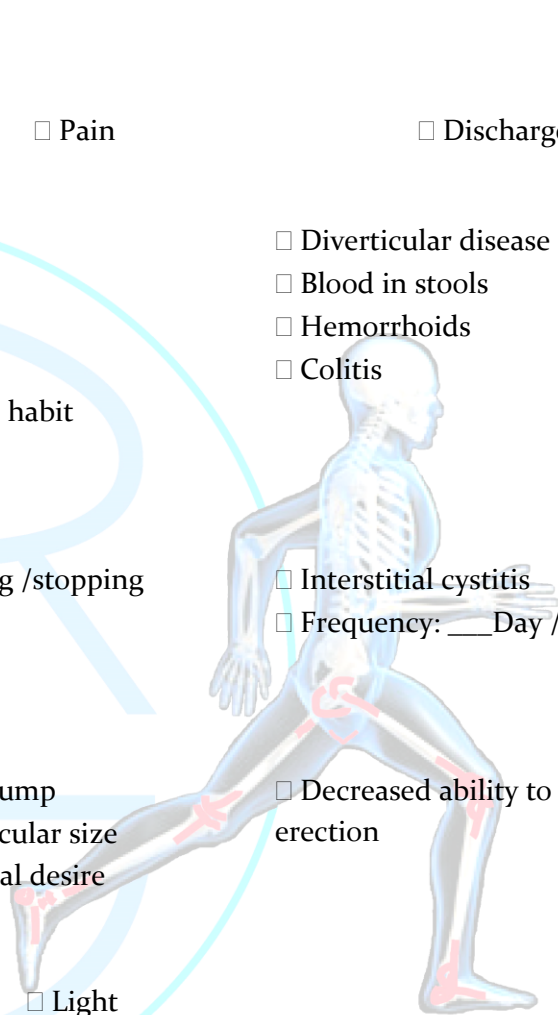
Bleeding between cycle: _____ Age of onset: _____

Days between Period: _____ Duration: _____

Date of your last normal period: ____/____/____

Menopause onset: _____

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



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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Hypothyroidism (underactive) | <input type="checkbox"/> Heat/Cold intolerance |
| <input type="checkbox"/> Hyperthyroidism (overactive) | <input type="checkbox"/> Hashimotos Thyroiditis | |
| <input type="checkbox"/> Change in body hair (face, underarms, or pubic) | <input type="checkbox"/> Diabetes Type I or II | |
| | <input type="checkbox"/> Increased thirst | |

Neurologic/Psychiatric:

- | | | |
|----------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Nervousness |
|----------------------------------|-------------------------------------|--------------------------------------|

Sleep Difficulty

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

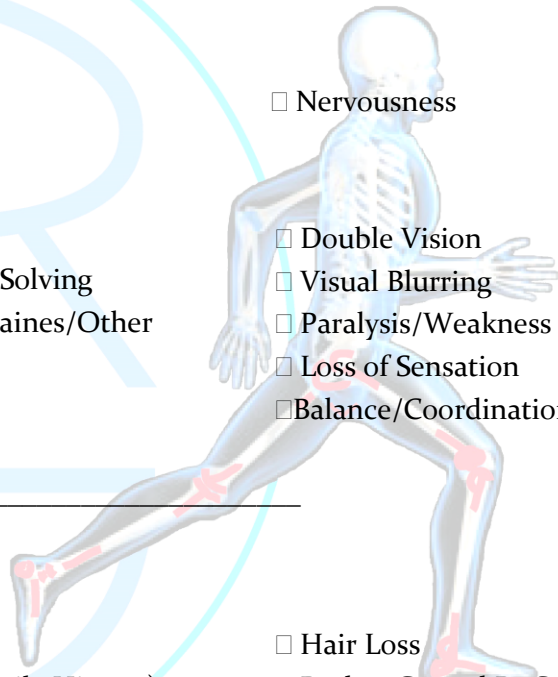
Skin:

- | | | |
|--|--|--|
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Psoriasis (Or Family History) | <input type="checkbox"/> Rashes Caused By Sunlight |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Change in Skin Color |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Nail Changes | <input type="checkbox"/> Skin Ulcers |
| <input type="checkbox"/> Welts | <input type="checkbox"/> Change in Texture of the Hair | |
| <input type="checkbox"/> Change of Finger Color in the Cold: ___Blue / ___White / ___Red | | |

Musculoskeletal:

Extremities:

- | | | |
|------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Heat | <input type="checkbox"/> Deformities | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Double Jointed | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Scoliosis/Kyphosis | |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Muscle pain/weakness | |
| <input type="checkbox"/> Stiffness | | |



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

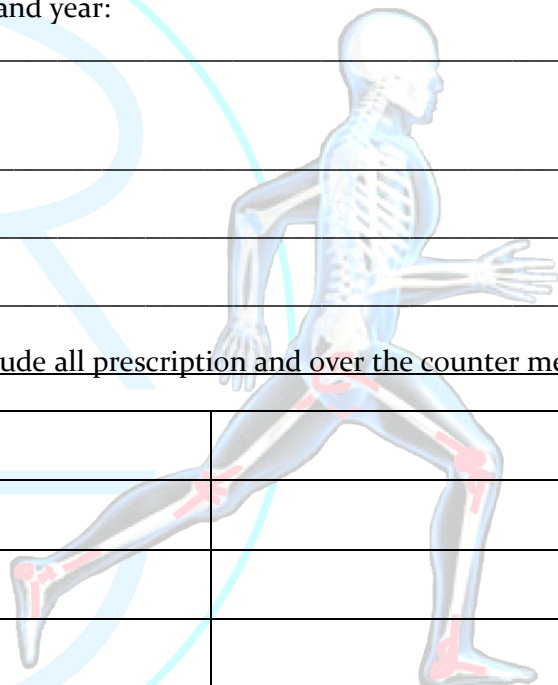
Please indicate the Body Prosthesis (Body Joint) - location and year:

Please list previous surgeries:

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

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)
- Ansaed (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)
- Sulfasalazine (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)

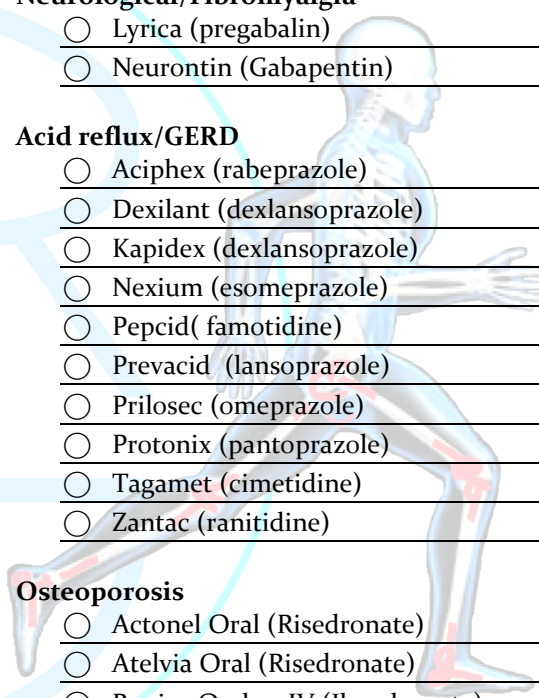
Osteoporosis

- 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 (Tizanidine)
- 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.