ARTHRITIS & RHEUMATOLOGY OF GA, PC

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ANNA ADAMS, PA-C CASHELLE ROSE, PA-C

NEW PATIENT REGISTRATION FORM

(Please Print)

Patient Information			
Patient's last name:	First name:		Middle:
Circle one: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	Marital Status: ☐ S ☐ M ☐ W ☐ D	Date of Birth:	Sex: ☐ M ☐ F
Street Address:			
P.O. Box	City:	State	Zip
Home phone #	Alternate phone #		
Email Address:			
Occupation:	Employer:	Employer Phone #:	
Referring Physician		Phone #:	
Primary Care Physician		Phone #:	
Spouse:		Phone #:	
Emergency Contact:		Phone #:	

Insurance Information		
Primary Insurance:		
Policy Holder's name (if other than self)		Policy Holder's D.O.B
Policy #	Group #	
Secondary Insurance:		
Policy Holder's name (if other than self)		Policy Holder's D.O.B
Policy #	Group #	

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 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: _____

Records may be forwarded to:

☐ Referring Physician

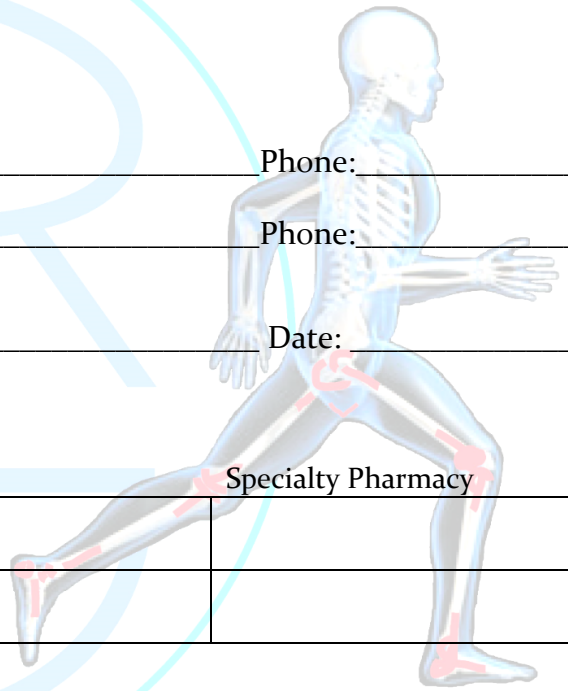
☐ Primary Care Physician

☐ Other Provider(s) please list

Additional Physician: _____Phone:_____

Additional Physician: _____Phone:_____

Patient Signature: _____ Date: _____



Pharmacy:

	Retail Pharmacy	Specialty Pharmacy
Pharmacy Name		
Phone Number		

Past Medical History:

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

☐ Allergies	☐ COPD	☐ Hypertension
☐ Anemia	☐ Coronary Artery Disease	☐ Irritable Bowel Disease
☐ Angina	☐ Depression	☐ Myocardial Infarction
☐ Anxiety	☐ Diabetes	☐ Osteoporosis
☐ Arthritis	☐ Elevated Lipids	☐ Renal Disease
☐ Asthma	☐ Gallbladder Disease	☐ Seizure Disorder
☐ Atrial Fibrillation	☐ GERD	☐ Stroke
☐ Blood Clots	☐ Headache, Migraine	☐ Thyroid Disease
☐ Cancer	☐Hepatitis/Liver Disease	☐ Other

Comments: (Year, complications, other):_____

Past Surgical History:

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

☐ Angioplasty	☐ Cataract Extraction	☐ Knee Replacement
☐ Appendectomy	☐ Cholecystectomy	☐ LASIK
☐ Arthroscopy	☐ Colectomy	☐ Mastectomy
☐ Back Surgery	☐ Colostomy	☐ ORIF
☐ Blood Transfusion	☐ Gastric Bypass	☐ Thyroidectomy
☐ CABG	☐ Hernia Repair	☐ Tonsillectomy
☐ Cardiac Pacemaker	☐ Hip Replacement	☐ Other
☐ Carpal Tunnel Release	☐ Hysterectomy	

Comments: (Year, complications, other):_____

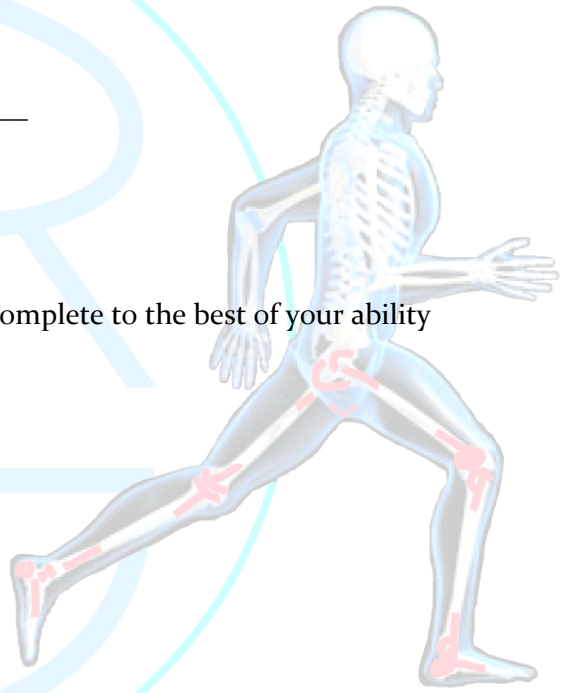
Immunizations (Approximate date if known):

PPD: ___/____/_____ Hepatitis B: ___/____/_____

Flu: ___/____/____ Pneumonia: ___/____/____

Family History/Illness:

Please check all family history of Rheumalogical diseases; complete to the best of your ability



☐ Ankylosing Spondylitis
☐ Bechet's
☐ Crohn's
☐ Gouty Arthritis
☐ Juvenile Arthritis
☐ Nephritis
☐ Osteoporosis
☐ Polymyositis
☐ Psoriatic Arthritis
☐ Raynaud's
☐ Rheumatoid Arthritis
☐ Sarcoidosis
☐ Sjorgren's Syndrome
☐ Systemic Lupus
☐ Thyroid Disease

Social History:

Have you ever been a smoker?_____

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

Have you ever tried to quit smoking?_____ Year?_____

Have you ever lived with a smoker?

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

Drugs (Marijuana, other):_____

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:

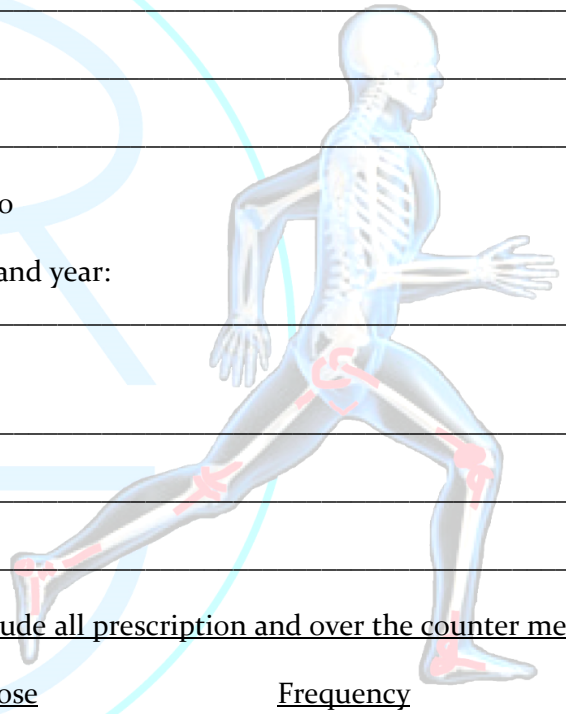
_____

Please list previous surgeries:

_____

_____

_____



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

Name	Dose	Frequency

Medication ALLERGIES and Symptoms:

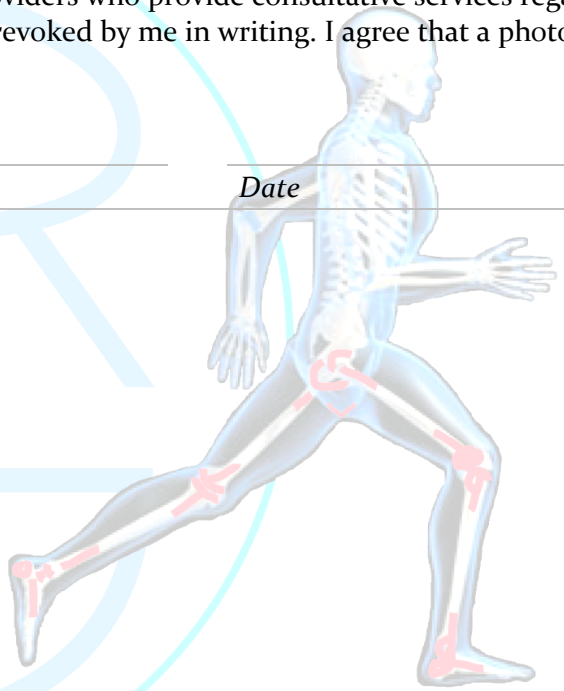
_____

_____

Completed By: _____DATE:_____

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*



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. ***