Southwest Arthritis Research Group

1600 Republic Parkway #200, Mesquite, TX 75150

INITIAL VISIT: Please answer each section by either writing in the space below or circling one of the options listed. This information is *confidential* and will not be released without your permission.

Your Name _____ Age_____
Your Family physician_____ Phone#_____
Physicians Address _____
Who do you want information/reports sent to? Yourself__Family MD___Other MD___

ABOUT YOUR ARTHITIS: What are your problems?_____
Symptoms First Began: Month/Year _____
Most Affected Areas: Hand___Feet___Shoulders___Knees___Hips___Back__Neck__
First Diagnosed as:_____By Dr._____
Have you ever seen a Rheumatologist? Yes/No Who?_____
I have been told I have:

□ LUPUS	□PSORIASIS/PSORIATIC ARTHITIS	□ GOUT
□OSTEOARTHRITIS	□RHEUMATOID ARTHRITIS	□ FIBROMYALGIA
□SCLERODERMA	□POLYMYOSITIS	□ VASCULITIS
□SPONDYLITIS	□JUVENILE RHEUMATOID ARTHITIS	□SJORGREN'S

What Tests Abnormal(circle)? ANA SedRate(ESR) RF(rheumatoid factor) Uric Acid

My Sleep is(circle): Great Normal Fair Poor Very Poor Wake up tired

Do you have Morning stiffness (how long)? None 15min 30min 45min 1hr 2hr 4hr

OTHER MEDICAL PROBLEMS (Please check all that apply)

□Diabetes	□Lung Disease	□Hepatitis/Jaundice	□Thyroid Problems
□Hypertension	□Asthma	□Psoriasis	□Joint Surgery
□Heart Disease	□Stomach Ulcers	□Bleeding Ulcers	□Plastic Surgery
□Stroke	□Colitis	□Osteoporosis	□Fractures
□Irregular Heartbeat	□Kidney Disease	□Depression	□Hospitalization

DO YOU HAVE: (now or in the past)

□Weight loss	□Skin ulcers	□Jaw Pain	□Chest pain
□Weight gain	□Hives	□Hearing Problems	□Cough
□Fever	□Itching	□Swollen glands	□Short of breath
□Weakness	□Hair falling out	□Peptic Ulcers	□Wheezing
□Fatigue	□Abnormal nails	□Heartburn	□Purple/white fingers
□Night Sweats	□Easy bruising	□Indigestion	□Swelling in legs/feet
□Joint Pains	□Sores in mouth	□Nausea	□Lower back pain
□Swollen Joints	□Dental Problems	□Vomiting	□Red "pink" eyes
□Pain in Muscles	□Dry mouth	□Swallowing problems	□Menopause
□Tendonitis	□Dry eyes	□Heel pain	□Numbness
□Bursitis	□Eye pain	□Diarrhea	□Discharge (vaginal or penile)
□Gastritis	□Menstrual problems	□Constipation	
□Nodules(knots)	□Vision problems	□Diverticulitis	□Pain on urination
□Skin rash	□Nosebleeds	□Blood in stool	
□Psoriasis	□Chronic sinusitis	□Difficulty sleeping	
□Tight skin	□Ringing in ears	□Hemorrhoids	
□Loss of memory	□Depression	□Jaundice	

Southwest Arthritis Research Group

1600 Republic Parkway #200, Mesquite, TX 75150

Name _____

List Your Vitamins, Etc. _____

List All Current Medications: _____

_____

_____

_____

What Are You Allergic To: _____

Have You Ever Taken Any Of These Medications? (Check all that apply):

DMARDs	Biologics	NSAIDs	Osteoporosis
□Hydroxychloroquine (Plaquenil) □Sulfasalazine (Azulfidine) □Leflunomide (Arava) □Methotrexate □Ciclosporin □Cyclphosphamide □Hydroxychloroquine □Mycophenolate (Cellcept) □Otezla □Other:	□Abatacept (Orencia) □Rituximab (Rituxan) □Golimumab(Simponi Simponi Aria) □ Actemra □ Humira □Certolizumab (Cimzia) □Etanercept (Enbrel) □Infliximab (Remicade) □Stellara □Xeljanz	□Naproxen (Aleve, Anaprox, Naprosyn) □Ibuprofen (Advil, Motrin) □Aspirin □Diclofenac □Celecoxib (Celebrex) □Indomethacin (Indocin) □Ketorolac (Toradol) □Piroxicam (Feldene) □Other:	□Actonel □Boniva □Zoledronic Acid (Reclast or Zometa) □Evista □Forteo □Calcitonin □Prolia □Other

Work, Lifestyle & Family:

Current Job_____ Employer _____Stress level_____

Marital Status: Single Married Divorced Separated Widowed Other:_____

Who lives with you?_____ Pets at home?_____ Foreign Travel: Yes/No

Do you smoke? NEVER NO(QUIT____yrs. Ago) YES(Packs per day?)_____

Do you drink alcohol? NEVER I QUIT RARELY SOCIALLY DAILY

Hepatitis B or C Risk Factors: Blood Transfusion/Contact with blood or body fluids/Tattoos Body piercing / Shared Razor or Tooth brush/ Multiple Sexual Partners

Does anyone in your family have ARTHRITIS?_____

In the PAST WEEK, how much PAIN have you experienced? (Place mark through the line below)

NO PAIN 1.....10 MOST SERVER PAIN

Southwest Arthritis Research Group

1600 Republic Parkway #200, Mesquite, TX 75150

Confidential Health Information Enclosed

This Fax contains confidential health care information that is personal and sensitive information. It is being faxed 10 you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, may be obligated under Federal or State Law to maintain the information in a safe, secure and confidential manner. Re-disclosure without additional patient permission or as otherwise permitted by law may be prohibited. Unauthorized re-disclosure or failure to, maintain confidentiality could subject you to penalties under Federal Law.

Southwest Arthritis Research Group
1600 Republic Parkway, Suite 200
Mesquite, TX 75150
Atul K. Singhal, M.D.
Megha Patel-Banker, M.D.
Carmen M. Campbell, M.D.
Phone: 972-288-2600 Fax: 972-288-8886

Authorization for Release of Records

The undersigned hereby authorizes and requests Dr._____
to provide *Southwest Arthritis Research Group* with access to the medical and treatment records of
Name: _____D.O.B _____
for the purpose of continuing treatment. I release you from all legal responsibility or liability that may arise from the authorization. **Authorization is valid for 180 days.**
Signed: _____Date_____

Witness:_____

Southwest Arthritis Research Group

1600 Republic Parkway #200, Mesquite, TX 75150

Patient Questionnaire for HIPPA Compliance

Preferred Method of Communication

*My preferred method of communication regarding my **medical condition, appointment reminders, and billing** is indicated below **(Check one):***

- ☐ *Home Phone*
- ☐ *Work Phone*
- ☐ *To receive appointment reminders by text please leave cell number below*
- ☐ *For access to our patient portal please leave email below*

*Cell:*_____

Email: _____

Please notify us of any updates that need to be made to your information asap.

Approved HIPPA Contacts

Keeping your information private is important to us. And, by default, we will disclose your information to you only.

If you would like to add additional contacts that SWARG is allowed to disclose your information to, please complete the fields below. Select the appropriate checkboxes based on your approval for each person you list. In addition, please select an Emergency Contact.*

1. Contact Name _____ Relationship to Patient _____ Contact Phone Number _____

- ☐ Billing Account Information
- ☐ Medical Condition Information
- ☐ Emergency Contact

2. Contact Name _____ Relationship to Patient _____ Contact Phone Number _____

- ☐ Billing Account Information
- ☐ Medical Condition Information
- ☐ Emergency Contact

1. I acknowledge that a HIPPA Privacy Policy has been made available to me for review in the office of SWARG located in the waiting room area and exam rooms . If unable to locate a copy please see our HIPPA Privacy Policy Officer

2. If I am ever in an unsecured area within the practice, and requires privacy, for any reason, I will request to be moved to a private area to complete my needed transactions or correspondence (financial, treatment plan, diagnosis, etc.)

Patient Name (Please Print) Signature Date

Southwest Arthritis Research Group

1600 Republic Parkway #200, Mesquite, TX 75150

Demographic Form

Patient Information

Patient Last Name	*First Name*	*Middle Name*	*Preferred Name*
Address		*City* / *State* / *Zip Code*	
Home Phone	*Mobile Phone*	*Work Phone*	*Preferred Number:* Home / Cell / Work
Email (Please Print Clearly in Uppercase)		*Marital Status* Single Married Divorced Widow	
Social Security Number (Optional)		*Sex* Male Female	*Date of Birth*
Primary Care Physician Name & Address		*Phone #*	*Fax #*
Referring Physician Name & Address		*Phone #*	*Fax #*

Southwest Arthritis Research, P.A offers several clinical drug trials through Pharmaceutical companies and we would like to offer these opportunities to you. Please indicate below if we may contact you (Check one):

- ☐ Yes, Please contact me
- ☐ No, Please don't contact me

Assignment of Medical Benefits

I hereby assign all medical benefits to which I am entitled, private insurance and other health plan to ***Southwest Arthritis Research Group, P.A****. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for all charges whether or not paid by said insurance company. I hereby authorize said assignee to release all information necessary to secure payment on my behalf.*

_____ _____

Signature Date