PACIFIC RHEUMATOLOGY ASSOCIATES MEDICAL GROUP
2100 WEBSTER STREET, SUITE 112, SAN FRANCISCO, CA 94115
PHONE: (415) 923-3060 FAX: (415) 749-0841

PLEASE COMPLETE ALL THE INFORMATION 11AND USE BLACK OR BLUE INK

Today's Date: _____

Name: _____ , _____ Date of Birth: _____
LAST NAME FIRST NAME MM / DD / YEAR

Gender: _____ Marital Status: Single / Married / Widowed / Divorced

Ethnicity:_____ Race: _____ Primary Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone:_____

Email: _____ Social Security #: _____

Employer: _____ Occupation: _____☐ Full-Time / ☐ Part-Time / ☐ Retired

Education: ☐ High School ☐ College ☐ Grad School **Are you a veteran?** ☐ Yes / ☐ No

Preferred Pharmacy & Address/ Phone #: _____

INSURANCE INFORMATION

Name of **Primary** Insurance: _____

ID #: _____ Group #: _____

Address: _____ Phone #: _____

If other than self, Name of Insured Person: _____

Relation to Insured Person: _____ DOB: _____

Name of **Secondary** Insurance: _____

ID #: _____ Group #: _____

Prescription Insurance (if separate from medical): _____ ID#: _____

DOCTOR'S INFORMATION

Name of Primary Care Physician: _____ Phone #: _____

Name of Referring Physician: _____Phone #: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone #: _____

Relationship: _____

PLEASE READ AND BE SURE TO SIGN:

I hereby give authorization for payment of insurance benefits to be made directly to my physician for services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance or not. I hereby authorize the release of all information necessary to secure the payment of benefit, and I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ **Date:** _____

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PATIENT HISTORY FORM

Name: _____ , _____ Date of Birth: _____
LAST NAME FIRST NAME MM/DD/YEAR

Briefly describe your present symptoms: _____

Previous treatment for this problem (i.e., Physical therapy, Medication, Surgery, Other): _____

Current Medications:

Name & Dose:	Name & Dose:	Name & Dose:
1) _____	6) _____	11) _____
2) _____	7) _____	12) _____
3) _____	8) _____	13) _____
4) _____	9) _____	14) _____
5) _____	10) _____	15) _____

ALLERGY to any medication? ☐ No / ☐ Yes If yes, please list: _____

Rheumatology / Arthritis History:

Yourself	Family Member (State Relationship)		Yourself	Family Member (State Relationship)	
☐		Osteoarthritis	☐		Lupus / SLE
☐		Gout	☐		Rheumatoid Arthritis
☐		Juvenile Arthritis	☐		Spondyloarthropathy (i.e., A.S., Psoriatic Arthritis, etc.)
☐		Vasculitis (Type)	☐		Osteoporosis

Past Medical History: _____

Past Surgical History: _____

Social Hx: Do you smoke? ☐ Yes, ☐ No, ☐ Past **Do you drink alcohol?** ☐ Yes, ☐ No, ☐ Past **How much weekly?** _____
Do you use drugs (not prescribed)? ☐ Yes, ☐ No, ☐ Past **How much sleep do you get a day?** _____
Do you exercise regularly (type, frequency)? _____
Have you traveled in the past year (where)? _____
Have you ever been pregnant? ☐ Yes, ☐ No **How many live births have you had?** _____ **Complications?** _____

Review of Symptoms (Please check if you are currently or recently experiencing any of these symptoms):
☐ Fatigue, ☐Weight Loss, ☐Weight Gain, ☐Fever, ☐Night Sweats, ☐Dry Eye, ☐Eye Pain, ☐Loss of Vision, ☐Tinnitus,
☐ Hearing Loss, ☐Nosebleed, ☐Sneezing, ☐Dry Mouth, ☐Canker Sores, ☐Cold Sores, ☐Loss of Smell or Taste,
☐ Difficulty Swallowing, ☐Sore Throat, ☐Bleeding Gums, ☐Hoarse Voice, ☐Chest Pain, ☐Shortness of Breath,
☐ High Blood Pressure, ☐Low Blood Pressure, ☐Heart Murmurs, ☐Cough, ☐Nausea, ☐Vomiting, ☐Diarrhea, ☐Abdominal Pain,
☐ Constipation, ☐Blood in Stool, ☐Heartburn, ☐Difficulty Urine, ☐Urine Infection, ☐Vaginal Ulcers, ☐STDs,
☐ Nighttime Urination, ☐Incontinence, ☐Stiffness, ☐Joint Pain, ☐Joint Swelling, ☐Muscle Pain, ☐Weakness,
☐ Numbness/Tingling, ☐Rash, ☐Psoriasis, ☐Bruising, ☐Skin Nodule, ☐Skin Ulcer, ☐Color changes in Hands/Feet when Cold,
☐ Headaches, ☐Dizziness, ☐Loss of Consciousness, ☐Falling, ☐Memory Loss, ☐Anxiety, ☐Depression, ☐Anger, ☐PTSD,
☐ Difficulty Falling Asleep, ☐Difficulty Staying Asleep, ☐Swollen Glands, ☐Tender Glands, ☐Anemia, ☐Transfusions, ☐Cancer

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ACTIVITIES OF DAILY LIVING

How many people in household? (List age & relationship):

_____

Who does most of the shopping? _____ Most housework/yardwork? _____
What is the hardest thing for you to do? _____

Please check the ONE best answer for your abilities at this time:

	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 of feeling blue?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3

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 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, acknowledge that I have received the **"Notice of Privacy Practices"** from Pacific Rheumatology Associates Medical Group. I understand that my record at the office will only be released in accordance to HIPAA Guidelines and California State Law.

My record will be released upon my written authorization. I also authorize the following person(s) to receive my medical information over the telephone from your office and make appointments on my behalf as my Representative:

I would like to authorize the following person(s):

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

☐ **I decline to name anyone under the Notice of Privacy Practices.**

_____ _____

PATIENT'S SIGNATURE DATE

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RECEIPT OF NOTICE OF THE OPEN PAYMENTS DATABASE

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at:
https://openpaymentsdata.cms.gov

_____ _____
PATIENT'S NAME DATE

_____
PATIENTS SIGNATURE

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

-Treatment means providing, coordination, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
-Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example we may disclose treatment information when billing a medical plan for your medical services.
-Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regard to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

-The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
-The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
-The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed. -The right to request an amendment to your protected health information. We may deny your request in certain situations.
-The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations….or based on your previous authorization.
-The right to obtain a paper copy of this notice from us upon request, event if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is revised as of February 2005, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Privacy Officer: Molly Magnano, M.D.
Pacific Rheumatology Associates Medical Group
2100 Webster St., Suite 112
San Francisco, CA 94115
415-923-3060

For more information about HIPAA or to file a complaint:

The U.S. Dept. of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)