ARTHRITIS & RHEUMATOLOGY CENTER OF SOUTH FLORIDA

Jigar Shah, M.D., F.A.C.R
5901 Colonial Drive, Suite 303 Margate FL 33063
Ph: 954-281-8891
Fax: 954-375-9664

First name:_____ Last name:_____

Home Address:_____ APT #:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work:_____ Cell:_____

Email Address:_____

Date of Birth:_____ Social Security #: _____

Race: ____White _____Asian _____Black/ African American ____Hawaiian ____Pacific Islander

Ethnicity: ____ Hispanic/Latino ____Not Hispanic/Latino Language Spoken:_____

Marital Status: ____Single ____Married ____Divorced ____Widowed

Sex: ____Female ____Male

Family Physician (PCP):_____ Phone #_____

Insurance Carrier:_____ Insured's SSN:_____

Insured's Name: _____ Insured's Birth Date:_____

Insured's ID number:_____ Insured's Group number:_____

Insured's Employer:_____ Insured's Relationship to patient:_____

Secondary Insurance Carrier:_____ Insured's SSN:_____

Insured's Name: _____ Insured's Birth Date: _____

Insured's ID number:_____ Insured's Group number:_____

Insured's Employer:_____ Insured's Relationship to patient:_____

Emergency Contact Information:

Name:_____ Phone:_____

Relationship to Patient: _____

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RHEUMATOLOGY PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: Birthdate: _____/_____/_____

_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

Whom do we thank for referring you here? _____

Name of your primary care physician: _____

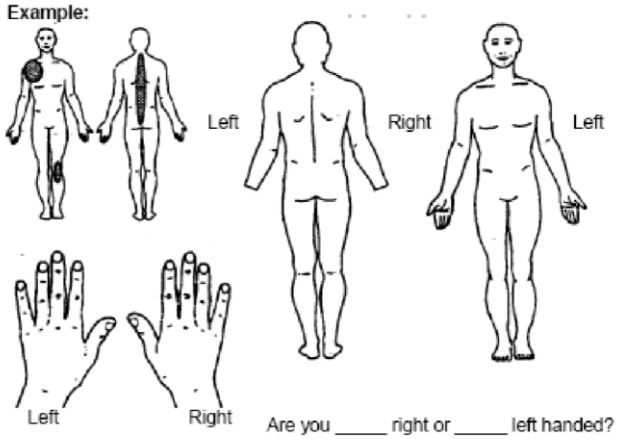
Describe briefly your present symptoms:

When did your symptoms start?

What diagnosis have you been given, if any?

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

Please list the names of other practitioners you have seen for this problem:

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

	Yourself	Relative		Name/relationship
Arthritis (type unknown)	❑	❑		
Osteoarthritis	❑	❑		
Rheumatoid arthritis	❑	❑		
Gout	❑	❑		
Lupus or "SLE"	❑	❑		
Ankylosing spondylitis	❑	❑		
Childhood arthritis	❑	❑		
Sjogren's syndrome	❑	❑		
Osteoporosis	❑	❑		
Psoriasis/psoriatic arthritis	❑	❑		

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) _____
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems
❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones
❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS

Any previous Fracture ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No ❑ In the past - How long ago? _____

Do you drink alcohol? ❑ No ❑ Yes : Usual drink: _____ How much: _____

Has anyone ever told you to cut down on your drinking? ❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ No ❑ Yes If yes, please list: _____ Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Name of drug	Dose (include strength and number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

SYSTEMS REVIEW

Date of last eye exam _____ Date of last chest x-ray _____

Date of last bone density test _____

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Morning stiffness
  Lasting how long ____ Minutes
  ____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

List joints affected in the last 6 months

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw while chewing

NECK
- ❑ Swollen glands
- ❑ Tender glands

HEART AND LUNGS
- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood ❑ Headaches
- ❑ Wheezing ❑ Dizziness
- ❑ Fainting or loss of consciousness

BLOOD
- ❑ Anemia
- ❑ Bleeding tendency

SKIN
- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive
- ❑ Skin tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM
- ❑ Numbness or tingling in hands/feet
- ❑ Memory loss
- ❑ Muscle weakness

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye

MOUTH
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑Loss of taste
- ❑ Dryness
- ❑ Recent increase in tooth cavities

NOSE
- ❑ Nosebleeds
- ❑ Loss of smell

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain relieved by food
- ❑ Vomiting of blood/"coffee grounds"
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

KIDNEY/URINE/BLADDER
- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Frequent urination
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For women only:

Age when periods began: _____

Number of pregnancies: _____

Number of miscarriages: _____

Have you reached menopause?

❑ No ❑ Yes If yes, at what age: ____

Date of last Pap smear: _____

Date of last mammogram: _____

If you are still having periods:

Are they regular? ❑ Yes ❑ No

How many days apart? _____

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HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as “HIPAA”).

This authorization affects your rights in the privacy of your personal health care information (PHI). Please read it carefully before signing.

Arthritis & Rheumatology Center of South Florida will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization, you acknowledge and agree that Arthritis & Rheumatology Center of South Florida may use or disclose medical records, treatment notes, test results or any other part of the medical chart for the purpose of medical treatment, processing or collecting financial reimbursements.

By signing this authorization, you agree Arthritis & Rheumatology Center of South Florida or its Business Associates may disclose your personal health care information to other treating physician’s or insurance companies or other collection agencies if needed.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Arthritis & Rheumatology Center of South Florida HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by

Arthritis & Rheumatology Center of South Florida for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization; (b) a

finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA; (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity; or (d) six years from the date this authorization was executed.

By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA. This form also allows Arthritis & Rheumatology Center of South Florida to call my phone number on record for reminder of appointments, test results or financial information.

Print Patient's Name: _____

Patient's Signature: _____

Date: _____

If you are signing as the patient's representative:

Print Name & Relationship: _____

Signature of Other: _____

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Authorization for Insurance/Credit Card Payment

I, _____ authorize any holder of medical or other information about me to release to my Insurance Carrier(s) or to the billing agent, of Arthritis & Rheumatology Center of South Florida, any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the part who accepts assignments.

Cardholder Name (as shown on card) _____

Card Number _____

Exp Date (mm/yy) _____

I,_____, authorize Arthritis and Rheumatology Center of South Florida to charge my card for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization will remain in effect until I (we) cancel this authorization, to cancel you must give a 60 day notice and account must be in good standing. I understand that my information will be saved to file for future transactions on my account.

Patient's Signature: _____

Date: _____

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Financial Policy

We appreciate the opportunity to provide medical services to you. Our goal is to keep your financial arrangements as simple as possible by timely filing all claims and by using the following guidelines:

1. You are ultimately responsible for payment of charges for services rendered at our office.
2. A fee of $25 will be added to your account for any check dishonored by your bank.
3. It is your responsibility to provide us with your current address, phone number and insurance information at each visit.
4. It is your responsibility to confirm with your insurance carrier that our doctor is "in-network" prior to seeing the doctor. If you choose to see a provider who is not on your plan, you are responsible for payment in full.
5. If you have an HMO insurance policy that requires a referral from your primary care physician, it is your responsibility to obtain the referral prior to services.
6. All copays and deductibles are due at the time of service.
7. If you miss your appointment or cancel the appointment prior to a 24 hour notice no show fee of $50 will be applied to your account.
8. A $50 administrative service fee will be applied for forms to be filled out by the doctor. These forms may include FMLA and Disability.

By signing below, I acknowledge that I understand and agree with the terms of this financial policy. Furthermore, I authorize payment of benefits to the Arthritis & Rheumatology Center of South Florida for services rendered under the terms of my insurance policy.

Print Name: _____ Signature: _____

Date: _____

If you are signing as the patient's representative:

Print Name & Relationship: _____

Signature of Other: _____

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No-Show Policy

Dear Patients:

We understand that there are legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling well in advance if you are unable to keep an appointment. We would like to have an option to offer that appointment to another patient who needs to see the doctor. Please let this notice serve to notify you that if you fail to give us a 24-hour notice of cancellation, there will be a $50.00 cancellation fee billed to your account that cannot be filed to your insurance.

Printed Name: _____
Date:_____

Signature: _____

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Narcotic Agreement

Narcotic agreement is being executed today to prevent misunderstandings about opioid analgesics I will be taking for pain management. This is to help me and my healthcare provider comply with the law regarding controlled pharmaceuticals. The goal of my treatment is to reduce pain to a level that is tolerable and allow me to improve day-to-day functioning. I understand that there are alternative treatments available including non-narcotic analgesics, physical therapy modalities including neuromuscular reeducation, psychological intervention, invasive procedures including injections and surgery.

I understand that narcotic medication may cause side effects including but not limited to nausea, vomiting, constipation, dry mouth, fluid retention, weight gain, weight loss, hormone suppression, itching, allergic reaction and if taking improperly may lead to excessive sedation, respiratory depression and death.

I understand that intolerance may develop and higher dose may be required to achieve adequate pain relief I understand that narcotics are likely to induce physical dependence and that abrupt withdrawal is likely to cause withdrawal symptoms. I understand that physical dependence and tolerance are different from addiction, which refer to psychological dependence on medication for purposes other than pain relief.
By signing I agree that Arthritis & Rheumatology Center of South Florida will be the sole provider of narcotic medication and I will not exceed prescribed dose. I understand that using my medicine at a rate greater then prescribed will result in my being without medication for a period of time. Lost prescriptions or medications including those stolen or inaccessible will not be replaced.

I agree to refrain from the use of illegal drugs and excessive alcohol. Noncompliance with the agreement may be grounds for discharge from the medical practice. Monthly visits will be required for medications that are not refillable.

No refills will be available during evening or weekend hours.

I agree to use only one pharmacy for filling narcotic prescriptions. The name, address and telephone number will be given to the office.

Patients may be subject to random urine or blood monitoring.

I certify that I've never been involved in the sale, illegal possession, diversion nor transport of controlled substances.

I authorize the physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this states Board of Pharmacy, in any investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my physician to provide a copy of this agreement to my pharmacy. I agree to allow the physician to communicate with other physicians and any pharmacists regarding use of controlled substances.

My signature below signifies that I've read each article in this document and my questions and concerns regarding treatment have been answered. I agree to abide by its requirements.

Signature: _____
Date:_____

Physician's Certification:

I have reviewed the above document with the patient whose signature appears above. I believe that this patient suffers from chronic pain and that this patient is a candidate for pain management with opioid analgesics. This patient agrees that Arthritis & Rheumatology Center of South Florida will be the sole prescriber of narcotic medications and will not exceed prescribed doses. Noncompliance with this contract may be grounds for discharge from the medical practice.

Physician Signature:

_____

Date: _____

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Consent for Procedures

It is very important to us that you understand and consent to the treatment your doctor is providing and any procedure your doctor may perform. You should be involved in any and all decisions concerning all procedures your doctor had recommended.
Sign this form only after you understand the procedure, the anticipated benefits, the risk, the alternatives, the risk associated with the alternatives and all of your questions have been answered. Please initial and date below this paragraph indicating your understanding of this paragraph.

Patient initials: _____ Date: _____

I, _____, hereby authorize Dr. Jigar Shah to perform all procedures. The doctor has explained to me the potential benefits of the procedure to me. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure. The doctor has explained to me that this procedure is generally recommended to treat other musculoskeletal conditions. The doctor has explained to me that there are risks and possible undesirable consequences associated with any procedure including but not limited to infection, chronic pain, chronic swelling, nerve pain, hematoma, worsening of the condition and nerve damage. Further, any of these risks or complications may require further surgical intervention after the procedure which I expressly authorize.

The reasonable alternative(s) to the procedure have been explained to me. I consent to any photographing or videotaping of the procedure that may be performed, provided my identity is not any unforeseen condition should arise during the course of the procedure, I do hereby authorize and request the physician to take whatever steps necessary to perform whatever procedure(s) they deem advisable, which may be in addition to or different from those now planned and have been discussed with me.

Signature: _____
Date: _____

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HIPPA Authorization Form

Patient Name: _____

Date Of Birth: _____

I have been provided with a notice of Privacy Practice of Dr. Jigar Shah M.D, F.A.C.R, that HIPPA outlines what will be done with my Protected Health Information.

The following person (or persons) may receive disclosure of protected health information about me:

1._____ Relationship: _____

2._____ Relationship: _____

3._____ Relationship: _____

I understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving I, and then would no longer be protected by Federal privacy regulations. I may revoke this authorization by notifying Arthritis and Rheumatology Center of South Florida in writing my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.

Signature: _____

Date: _____