Vanguard Rheumatology Partners

REGISTRATION FORM

(Please Print)

Today's Date:	Primary care doctor:	Referring doctor:

PATIENT INFORMATION

Patient's last name: First: Middle:	Sex ☐ M ☐ F	Age:	Marital status: ☐ Single ☐ Married ☐ Part ☐ Sep ☐ Div ☐ Widow

Birth date:	Email:	Home phone: ( )	Cell phone: ( )

Home address: Apt. #	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone: ( )
Pharmacy name:	Pharmacy address:	Pharmacy phone: ( )

Referred to our practice by :	☐ Dr.	☐ Insurance plan	☐ Hospital
	☐ Web search (Site:)	☐ Our website	☐ Family or friend

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary insurance:	Policy number:	Group number:	Employer sponsored: ☐ Yes ☐ No
Subscriber name:		Subscriber birth date:	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Secondary insurance (if applicable):	Policy number:	Group number:	Employer sponsored: ☐ Yes ☐ No
Subscriber name:		Subscriber birth date:	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Carlos A. Sesin, MD, PA (d/b/a Vanguard Rheumatology Partners) of benefits due to me from my insurance company otherwise payable to me. I further authorize the release of any medical information required by my health insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that I am financially responsible for charges not covered by this authorization. I further agree that if this account is referred to an agency or attorney for collection, I will be responsible for collection costs, attorney's fees and court costs.

Patient/Guardian signature *Date*

Vanguard Rheumatology Partners

PATIENT HISTORY FORM

(Please Print)

NAME:	**DATE:**

MEDICAL PROBLEMS

(check if you have any of the following conditions and/or any others)

☐ Osteoporosis	☐ Hepatitis B	☐ Raynaud's	☐ Diabetes	☐ Kidney disease
☐ Osteoarthritis	☐ Hepatitis C	☐ GERD (acid reflux)	☐ Hypothyroidism	☐ Kidney stones
☐ Fibromyalgia	☐ HIV	☐ Irritable bowel syndrome	☐ High blood calcium	☐ Prostate disease
☐ Gout	☐ Tuberculosis	☐ Stomach ulcers	☐ High cholesterol	☐ Cataracts
☐ Rheumatoid arthritis	☐ Shingles	☐ Diverticulitis	☐ Breast cancer	☐ Glaucoma
☐ Polymyalgia rheumatica	☐ Interstitial lung disease	☐ Crohn's disease	☐ Lung cancer	☐ Iritis or Uveitis
☐ Psoriatic arthritis	☐ Asthma	☐ Ulcerative colitis	☐ Colon cancer	☐ Blood clots
☐ Ankylosing spondylitis	☐ COPD	☐ Celiac disease	☐ Prostate cancer	☐ Stroke
☐ Lupus	☐ Emphysema	☐ High blood pressure	☐ Ovarian cancer	☐ Seizures
☐ Sjogren's	☐ Sleep apnea	☐ CHF	☐ Kidney cancer	☐ Migraines
☐ Vasculitis	☐ Psoriasis	☐ Heart disease	☐ Lymphoma	☐ Peripheral neuropathy
☐ Scleroderma	☐ Eczema	☐ Valve disease	☐ Leukemia	☐ Depression
☐ Dermatomyositis	☐ Chronic hives	☐ Atrial fibrillation	☐ Melanoma	☐ Anxiety
☐ Polymyositis	☐ Alopecia	☐ Pericarditis	☐ Other skin cancer	☐ Bipolar disorder

☐ Others:

MAJOR SURGERIES

(Please give approximate dates)

☐ Hip replacement Left ( ) Right ( )	☐ Cardiac stent	☐ Breast
☐ Knee replacement Left ( ) Right ( )	☐ Heart bypass	☐ Bariatric
☐ Knee arthroscopy Left ( ) Right ( )	☐ Heart valve	☐ Hysterectomy
☐ Shoulder replacement Left ( ) Right ( )	☐ Pacemaker	☐ Ovary
☐ Shoulder arthroscopy Left ( ) Right ( )	☐ Gallbladder	☐ Colon
☐ Lumbar spine surgery	☐ Prostate	☐ Lung
☐ Cervical spine surgery	☐ Bladder	☐ Cataracts
☐ Carpal tunnel release	☐ Appendix	☐ Skin cancer
☐ Other orthopedic surgery	☐ Thyroid	☐ Other

DRUG ALLERGIES

(Please list names of medications and reaction, e.g. penicillin causes rash)

☐ Penicillin	Reaction:	☐ Other:	Reaction:
☐ Sulfa	Reaction:	☐ Other:	Reaction:
☐ Iodine	Reaction:	☐ Other:	Reaction:
☐ Aspirin	Reaction:	☐ Other:	Reaction:
☐ Codeine	Reaction:	☐ Other:	Reaction:
☐ Tetracycline	Reaction:	☐ Other:	Reaction:

NAME:	DATE:

CURRENT PRESCRIPTION MEDICATIONS

(Please list names of medications and dosage)

Medication	Strength	Quantity taken	Times per day
(Example) Prednisone	5 mg	2 tabs	3 times per day

SMOKING

(Please check all that apply)

☐ Never smoker	☐ Some day smoker	☐ Every day smoker	☐ Former smoker
☐ Less than 1 pack a day	☐ 1-2 packs a day	☐ More than 2 packs a day	(Year quit _____)

ALCOHOL

(Please check all that apply)

☐ Never drink alcohol	☐ 1-2 drinks per day	☐ Previous alcohol abuse
☐ Less than 1 drink per day	☐ More than 2 drinks per day	☐ Other _____

FAMILY MEDICAL HISTORY

(Check all that apply. Please list any relevant medical problems)

Rheumatoid arthritis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other _____
Osteoporosis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other _____
Hip fracture	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other _____
Psoriasis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other _____
Gout	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other _____
Fibromyalgia	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other _____
Crohn's Disease or Ulcerative Colitis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other _____
Ulcerative Colitis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other _____
Ankylosing Spondylitis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other _____
Lupus	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other _____
Sjogren's Syndrome	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other _____
Scleroderma	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other _____
Dermatomyositis or Polymyositis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other _____
Other _____	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other _____

NAME:	DATE:

REVIEW OF SYMPTOMS

CONSTITUTIONAL	SKIN
☐ Fatigue or Tiredness	☐ Skin rash
☐ Fevers	☐ Psoriasis
☐ Night sweats	☐ Raynaud's phenomenon
☐ Weight loss	☐ Hair loss
☐ Other _____	☐ Sun sensitivity
EYES	☐ Other _____
☐ Dry eyes	**GENITOURINARY**
☐ Eye pain	☐ Painful urination
☐ Red eyes	☐ Urinary frequency
☐ Change in vision	☐ Blood in urine
☐ Other _____	☐ Genital ulcers
EAR/NOSE/THROAT	☐ Other _____
☐ Dry mouth	**HEMATOLOGIC/LYMPHATIC**
☐ Mouth ulcers	☐ Anemia
☐ Nasal ulcers	☐ Low white blood cell count
☐ Other _____	☐ Low platelet count
CARDIOVASCULAR	☐ Swollen glands
☐ Chest pain	☐ Other _____
☐ Palpitations	**ENDOCRINE**
☐ Other _____	☐ Heat/cold intolerance
GASTROINTESTINAL	☐ High blood calcium
☐ Heartburn	☐ Other _____
☐ Nausea/vomiting	**PSYCHOLOGICAL**
☐ Difficulty swallowing	☐ Anxiety
☐ Abdominal pain	☐ Depression
☐ Diarrhea	☐ Hallucinations
☐ Other _____	☐ Paranoid thoughts
RESPIRATORY	☐ Other _____
☐ Shortness of breath	**NEUROLOGICAL**
☐ Frequent cough	☐ Headache
☐ Wheezing	☐ Muscle weakness
☐ Other _____	☐ Memory loss
OB/GYN	☐ Loss of consciousness
☐ Premature delivery	☐ Seizures
☐ Miscarriages	☐ Other _____
☐ Pre-eclampsia/eclampsia	
☐ Other _____	

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

(Please complete, sign and date)

SECTION A: Patient Giving Consent

Name _____

Address _____

Telephone _____ Date of Birth _____

SECTION B: To the Patient - Please read the following statements carefully

Purpose of Consent. By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, research and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, research and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

Right to Revoke. You will have the right to revoke this Consent at any time by giving written notice of your revocation to our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, research and healthcare operations.

Signature: _____ Date: _____

If other than patient, relationship to patient _____

Vanguard Rheumatology Partners

FINANCIAL POLICY

(Please sign and date)

We are pleased that you have entrusted our physicians with your health care. In doing so, you can be assured that we are committed to providing you with the best medical care possible. We also appreciate that healthcare coverage can be complex and recognize the need to establish a clear and concise financial policy that helps you understand your responsibilities as a patient. As a policyholder of healthcare insurance, it is your responsibility to be an informed consumer. It is expected that you have an understanding of what your policy covers, know your copayment amounts, know if your plan requires a referral and if precertification is necessary for certain procedures. It is also your responsibility to be aware of any deductibles and coinsurances that may apply for both participating and non-participating physicians and facilities. We will do our best to assist you with understanding your proposed treatment and in answering questions relating to your insurance.

PAYMENT POLICY SCHEDULE

Co-payments	Full payment is due at the time of service. Failure to make payment will result in an additional $20.00 statement charge.
Deductible and coinsurance	Full payment is due at the time of service.
Non-covered service	Full payment is due at the time of service.
Non-participating insurance plan	Full payment is due at the time of service.
Missed Appointment Fee	The office requires at least 1 business days' notice when cancelling an appointment. Failure to provide this notice will result in a charge of $25.00.
Return Check Fee	A fee of $25.00 will be applied for any check returned.
Medical Records	A fee of $0.50 per page due prior to the release of records.

*Subject to change at any time

All non-covered balances older than sixty (60) days are considered overdue, unless other payment arrangements have been made. Such balances may be turned over to our collection agency. If this action becomes necessary, you will be responsible for all costs of collection fees, including interest.

We understand that medical care can often become very expensive and that temporary financial problems may affect your ability to pay on a timely basis. If such a situation should arise, we encourage you to contact us promptly for assistance. For further information about this or our financial policy, please do not hesitate to contact us at (305) 531-6766 between the hours of 9:00 AM – 5:00 PM, Monday through Friday.

I fully understand and agree to Vanguard Rheumatology Partners' Financial Policy:

_____ _____ _____

Patient's signature **Print Name** **Date**