West County Rheumatology

13100 Manchester Rd Ste 70 Saint Louis, Mo 63134

Office Phone: 314-492-2323 Office Fax :314-582-1010

Office Website: https://westcountyrheumatology.com/

New Patient Packet

Patient Information

Last Name _____ First Name _____

Address _____ City, State , Zip _____

Date of Birth _____ Sex [ ] Female [ ] Male Age_____

Cell phone _____Home Phone _____

Emergency Contact _____ Emergency Contact Phone _____

Pharmacy _____Pharmacy Phone _____

Insurance Name _____ID Number _____

Martial Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Race: [ ] American Indian or Alaska Native [ ] Asian [ ] Native Hawaiian or Pacific Islander [ ] Black or African American [ ] White [ ] Hispanic

I hereby authorize West County Rheumatology to administer treatment of the above-mentioned patient. I authorize West County Rheumatology to release any medical information acquired in the course of an examination or treatment of the above-named patient to his/her insurance company for payment. I authorize payment to be made directly to West County Rheumatology for any services rendered and understand that I am financially responsible to West County Rheumatology for charges not paid by insurance company.

Patient Signature:_____Date:_____

Family History

List any conditions that your family has had (**mother, father, brother, sister and grandparents**)
Write which family member on the line

- ☐ High Blood Pressure _____
- ☐ Cancer
- ☐ Rheumatoid Arthritis _____
- ☐ Joint Pain
- ☐ Autoimmune Disease_____
- ☐ Ulcerative Colitis_____
- ☐ Crohns Disease_____
- ☐ Psoriasis Inflammation _____
- ☐ Eye Disease_____
- ☐ Cardiovascular Disease_____
- ☐ Pulmonary Disease_____

List all drug allergies (including food, drug and environmental) [ ] No known Drug Allergies

Allergen:

_____

Type of Reaction: _____

List all medications (you are currently taking. Include such items as aspirin, vitamins, laxatives, and any natural supplements) **If you have a copy of your medication list we can make a copy**

Name of Medication	Dose	How Many Times per Day?	How long have you been taking this medication?

Social History

Have you ever used tobacco products? [] Yes [] No

Having you used chewing tobacco, cigarettes, cigars? [] Yes [] No

Do you currently Smoke? [] Yes [] No

What do you smoke?

Do you use a Vapor Pen? [] Yes [] No

Do you ever drink Alcohol? [] Yes [] No How Often? [] Everyday Monthly [] Weekly [] Rarely []

What Type of Alcohol?

Do you use recreational drugs? (cocaine, heroin, methamphetamine, marijuana)

[ ] Yes [] No

List all Surgeries (Hysterectomy, knee replacement, shoulder replacement, C- Section etc.)

Type of Surgery	Reason for Surgery	Year

Past Medical History

As your review the following list, please check any of those problems, which have significantly affected you.

CONSTITUTIONAL

- ☐ Weakness
- ☐ Cancer - Type _____

EYES

- ☐ Loss of vision
- ☐ Dry Eye

EAR-NOSE-MOUTH-THROAT

- ☐ Loss of hearing

CARDIOVASCULAR

- ☐ Heart murmurs
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Coronary artery disease
- ☐ Myocardial infarction
- ☐ Long QT syndrome

MUSCULOSKELETAL

- ☐ Ankylosing Spondylitis
- ☐ Rheumatoid Arthritis
- ☐ Connective Tissue Disease
- ☐ Dermatomyositis
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Polyarthropathy
- ☐ Polymyositis
- ☐ Scoliosis
- ☐ Scleroderma
- ☐ Lupus
- ☐ Sjogren's

GASTROINTESTINAL

- ☐ Jaundice
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Gastroesophageal reflux disease
- ☐ Constipation
- ☐ Crohns Disease/Ulcerative Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Peptic Ulcer

GENITOURINARY

- ☐ Chronic Urinary Tract Infection

RESPIRATORY

- ☐ Pulmonary Nodules
- ☐ Chronic obstructive pulmonary disease

INTEGUMENTARY (SKIN AND/OR BREAST)

- ☐ Psoriaris
- ☐ Raynauds

NEUROLOGICAL

- ☐ Headaches
- ☐ Transient ischemic attack
- ☐ cerebrovascular accident/stroke

HEMATOLOGIC/LYMPHATIC

- ☐ Anemia
- ☐ MTHFR
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Deep vein thrombosis
- ☐ Pulmonary embolism

ENDOCRINE

- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Diabetes Mellitus Type 1
- ☐ Diabetes Mellitus Type 2

ALLERGIC/IMMUNOLOGIC

- ☐ Increased susceptibility to infection

West County Rheumatology

West County Rheumatology HIPAA Authorization Form

I authorize West County Rheumatology to use and disclose the protected health information described below to all other providers involving in my care including but not limited to

Primary Care Physician:_____

Number: _____

Specialists:_____

Specialists:_____

Specialists:_____

I authorize the release of my complete medical records: Labs, Radiology, HIV or AIDS, psychiatric history and progress Notes. This medical information may be used by West County Rheumatology for medical treatment or consultation, billing or claims payment.

Signature of Patient _____ Date:_____

Printed Name _____ Date:_____

West County Rheumatology, LLC

13100 Manchester Rd #70, St. Louis, MO 63131
(314) 492-2323; Fax: 314-582-1010

Patient Name: _____ **D.O.B.:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared. I acknowledge West County Rheumatology, LLC and its staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern West County Rheumatology, LLC operations and responsibilities.

_____

Signature of Patient/Guardian/Parent | Relationship of Patient Representative to Patient | Date

_____

Signature of Witness | Printed Name of Witness | Date

Permission to Contact and Release of Information

In order to improve communications between the office and our patients, an automatic service may be utilized to confirm your appointment. Please check the following options below to receive your confirmation call:

Please contact me at: ☐ Home ☐ Cell ☐ Work

You may leave me a message at: ☐ Home ☐ Cell ☐ Work

I prefer to be contacted in the: ☐ Morning 8 am – 12 pm ☐ Afternoon 12 pm – 4 pm ☐ Evening 4 pm – 6 pm

There may be times when we need to speak to you personally regarding your appointment, to confirm your appointment, or to discuss your confidential health information. Please provide how and where you would like to be contacted. Please check the boxes below to indicate your preference.

Please contact me at: ☐ Home ☐ Cell ☐ Work

_____I request that you leave a message on my voicemail but only to indicate you have called and I will return your call.

_____You may at any time release my confidential health information to: (If no names are listed, we will not release any information.)

_____

Name | Relationship to Patient | Phone Type | Phone Number

_____

Emergency Contact | Relationship to Patient | Phone Type | Phone Number

_____

Primary Care Physician | Address | Phone Number

_____

Signature of Patient/Guardian/Parent | Printed Name | Date