INTEGRAL RHEUMATOLOGY & IMMUNOLOGY SPECIALISTS
140 SW 84th Avenue, Suite B, Plantation, FL 33324

PATIENT INFORMATION

Date: _____ Referred by: _____

Patient Name (last) _____ (first) _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: Cell: _____ D.O.B: _____ Sex: M / F

Primary Language: _____ Social Security #: _____ - _____ - _____

Driver's License #: _____ State: _____

Employer Name: Position: _____

Employer Address: _____

Work Phone: _____ Ext: _____

Marital Status: Single _____ Married ____ Divorced ____ Other: _____

Spouse's Name: _____ Employer: _____

DO YOU WANT COPIES SENT TO YOUR PERSONAL PHYSICIAN? YES _____ NO _____

AUTO ACCIDENT? YES____ NO____

ATTORNEY'S NAME: _____ Ph. _____

Nearest Relative or Friend Not Living With You _____

Relationship: _____ Phone: _____

Name of Policyholder: _____ DOB: _____

Policyholder's Social Security #: _____

Primary Ins. Co.: _____ ID#: _____

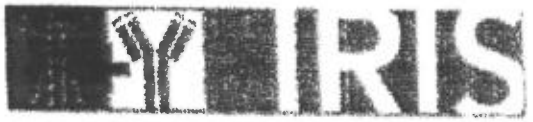
Secondary Ins. Co.: _____ ID#: _____

Today's payment will be made by (circle one): Check / Cash / Credit / Insurance Other _____

1 hereby authorize the payment of medical benefits to Integral Rheumatology & Immunology Specialists for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier. I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding. I hereby authorize Integral Rheumatology & Immunology Specialists to release any medical information necessary to complete and process my insurance claims. I authorize Integral Rheumatology & Immunology Specialists to treat me and use my personal health information for healthcare operations.

_____ _____ _____

Patient Signature Print Name Date



INTEGRAL RHEUMATOLOGY
& IMMUNOLOGY SPECIALISTS

Patient Name: _____ Date: _____

Standard Waiver of Liability:

I understand I am financially responsible for any charges incurred at this office, for those patients using insurance, this would include co-pays, deductibles, and charges denied or not covered by my insurance company.

Initial: _____

I **understand I am financially responsible for any laboratory charges requested by this office that are not covered by your insurance company.**

Initial: _____

*I understand I am fully responsible for obtaining my own referral at the time of service.

I realize my care may be subject to pre-authorization by my insurance company, and I accept responsibility for any charges incurred. My insurance company will review any/all documentation submitted by Dr. Guillermo Valenzuela MD, PA for review for medical necessity, however, final determination is based upon my insurance company's medical guidelines. Insurance policy limitations are per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals, etc.

I understand this office agrees to notify me as soon as possible whether my care is approved or denied by my insurance company. I understand the billing department may ask for my assistance in the appeal process if any charges are denied. These charges will be my responsibility if denied by my insurance company.

I will provide Guillermo Valenzuela MD, PA with any updated/accurate insurance information including but not limited to, primary and secondary insurance information.

I understand this office will require payment from me for any services not covered by my health insurance plan. Any payment due beyond 30 days is subject to late fees, interest at 1.5% per month and collection agency fees. I agree to pay all collection costs associated with collecting said debt, including, but not limited to attorney fees of 25%, together with the cost and disbursements of the action.

Signature: _____

CONTACT AUTHORIZATION

PATIENT NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME TELEPHONE: _____

All calls regarding your care, test results, and appointments will be made to your home phone. If you would like us to contact you at an alternate phone number, please indicate that number here:

#1: _____ #2: _____

- ❑ I hereby authorize this practice to contact me by phone and if I am not present they may leave a message on my answering machine.
- ❑ I prefer that this practice not leave a message if I am not present.

The following people, other than a duly designated guardian or conservator, are authorized to discuss my medical condition and/or billing information with a healthcare professional in this practice:

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

_____/_____/_____ _____

EXPIRATION DATE **SIGNATURE**

INTEGRAL RHEUMATOLOGY & IMMUNOLOGY SPECIALISTS140 SW 84th Avenue, Suite B, Plantation, FL 33324
PHONE: (954) 476-2338 FAX: (954) 476-5695

ACKNOWLEDGMENT AND CONSENT

I understand that IRIS - Integral Rheumatology and Immunology Specialists (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices. 1** also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and 1 understand that This Practice is not required by law to agree to such requests,

- **By signing below, I agree that have reviewed and understand the information above and that Ihave received a copy of the Notice of Privacy Practices.**

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient representative)

Description of Representative's Authority: _____

New Patient History Form

Name of your Primary Doctor:_____

Name of the Patient:_____ Date:_____

Briefly describe your symptoms:

_____

_____

What makes you feel better? (Medication, Movement, exercise, sleeping, activity, weather)

_____

_____

What makes you feel worse?

_____

_____

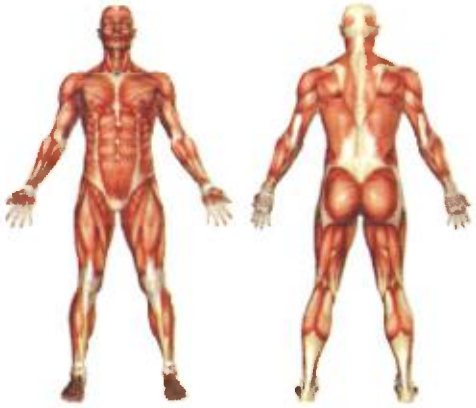
When did these symptoms start?

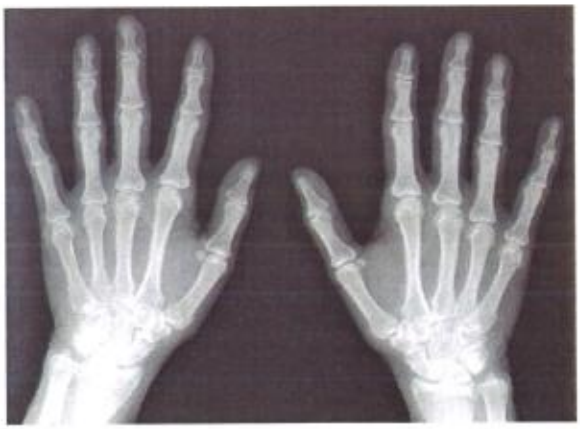
_____

_____

Do you have numbness when you wake up? YES___ NO____ How long does it last?_____

Please circle areas where you have pain:





Why are you here today?_____

Do you have an idea of why you're having the pain?

_____

PATIENT HISTORY

NAME:_____ DATE:_____

CONSTITUTIONAL
- ☐ Recent Weight Gain
  -Amount:_____
- ☐ Recent Weight Loss
  -Amount:_____
- ☐ Weakness

EYES
- ☐ Pain
- ☐ Redness
- ☐ Loss of Vision
- ☐ Double or Blurred Vision
- ☐ Dryness
- ☐ Feels Like Something in Eye
- ☐ Itching Eyes

EARS-NOSE-MOUTH-THROAT
- ☐ Ringing in Ears
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Loss of Smell
- ☐ Dryness in Nose
- ☐ Runny Nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐Sores in Mouth
- ☐ Loss of Taste
- ☐ Dryness in Mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in Swallowing

PSYCHIATRIC
- ☐ Excessive Worries
- ☐ Anxiety
- ☐ Easily Losing Temper
- ☐ Agitation
- ☐ Difficulty Falling Asleep
- ☐ Difficulty Staying Asleep

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Difficulty in Breathing at night
- ☐Swollen Legs or Feet
- ☐ Cough
- ☐ Coughing of Blood
- ☐ Wheezing (asthma)

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting of Blood or Coffee Ground Material.
- ☐ Stomach Pain relieved by food or milk.
- ☐ Jaundice
- ☐ Increasing Constipation
- ☐ Persistent diarrhea
- ☐ Blood in Stools
- ☐ Heartburn

NEUROLOGICAL SYSTEM
- ☐ Headaches
- ☐ Dizziness
- ☐ Muscle Spasm
- ☐ Loss of Consciousness
- ☐ Sensitivity or Pain of Hands or Feet
- ☐Memory Loss
- ☐ Night Sweats

ALLERGY/IMMUNOLOGIC
- ☐Frequent Sneezing
- ☐ Increased Susceptibility to Infection

HEMATOLOGIC/LYMPHATIC
- ☐ Swollen Glands
- ☐ Tender Glands
- ☐ Anemia
- ☐ Bleeding Tendency
- ☐ Transfusion/when:_____

MUSCULOSKELETAL
- ☐ Morning Stiffness

Lasting how long?_____
- ☐ Joint Pain
- ☐ Muscle Weakness
- ☐ Muscle Tenderness
- ☐ Joint Swelling

List joints affected in the last 6mos.

_____

_____

INTEGUMENTARY
(Skin &/or Breast)
- ☐ Easy Bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun Sensitive
- ☐ Tightness
- ☐ Nodules/Bumps
- ☐ Hair Loss
- ☐ Color Changes of Hands or Feet in the cold

ENDOCRINE
- ☐ Excessive Thirst

CARDIOVASCULAR
- ☐ Pain in Chest
- ☐ Irregular Heartbeat
- ☐ Sudden Changes in Heartbeat
- ☐ High Blood Pressure
- ☐ Heart Murmurs

<u>WOMEN ONLY:</u>

Age when period began:_
Period regular: Y____ N ____.
How many days apart?__
Depression: Y N ____.
Date of last period?__/__/____
Date of last pap?__/___/_____
Bleeding after menopause?_____
Number of pregnancies_____
Number of miscarriages_____

Past Medical History:

-Please list all physicians of these specialties you have seen including name and date:
(Orthopedic, Rheumatologist, Neurologist or pain specialist:

_____

_____

List all the doctors you are currently seeing:

_____

_____

Last set of X-rays (include dates and body parts):

_____

_____

Last MRI (include date and results):

_____

Last Bone Density (specify what parts of body):

_____

Last Mammogram (include date and results):

_____

Have you ever had Nerve Conduction Studies? (if yes when and result)

_____

Date of last blood work_____ Who ordered it?_____

Have you had colonoscopy (date and results):_____

Have you had a recent pap smear or prostate exam/PSA (date and results):

_____

Have you had any other imaging study not mentioned above, please specify:_____

_____

Have you ever had a fracture?_____ If YES, where & when:_____

Do you drink caffeinated beverages?_____ Amount:_____ Illegal drug use?_____

Do you exercise? Y N____ Type_____Amount per week:_____

Do you get enough sleep at night?_____ Wake up feeling rested?_____

Have you ever been to counseling or has anybody ever suggested it? Y_____ N_____ When?_____

Reason?_____

Education: Grade school- 7 8 9 10 11 12 College- 1 2 3 4 Graduate School in:_____

Occupation:_____ Number of hours worked/average per week:_____

Marital Status:_____ If single, do you live alone?_____ Number of children:_____

MEDICATIONS:

☐ Naprosyn	☐ Naproxen	☐ Aleve	☐ Motrin	☐ Rufen	☐ Ibuprofen
☐ Voltaren	☐ Arthrotec	☐ Diclofenac	☐ Aspirin	☐ Celebrex	☐ Celecoxib
☐ Vioxx	☐ Rofecoxib	☐ Bextra	☐ Valedecoxib	☐ Daypro	☐ Oxaporozin
☐ Disalcid	☐ Salsalate	☐ Dolobid	☐ Diflusinal	☐ Feldene	☐ Piroxicam
☐ Indocin	☐ Indomethocin	☐ Codine	☐ Etodolac	☐ Meclofenamate	☐ Nalfon
☐ Fenoprofen	☐ Oruvail	☐ Ketoprfoen	☐ Tolectin	☐ Tolmentin	☐ Trisalate
☐ Ansaid	☐ Fluribiprofen	☐ Clinoril	☐ Sulindac	☐ Acetaminophen	☐ Tylenol
☐ Codeine	☐ Vicodin	☐ Tylenol#3	☐ Propoxyphene	☐ Darvon	☐ Darvocet
☐ Percocet	☐ Oxycodone	☐ Hydrocondone	☐ Oxycontin	☐ Soma	☐ Flexeril
☐ Cyclobenzaprine	☐ Elavil	☐ Amitriptlyline	☐ Neurontin	☐ Gabapentin	☐ Provigil
☐ Lopamax	☐ Aderall	☐ Skelaxin	☐ Gabatril	☐ Methotrexate	☐ Aurofin Gold pills/shots
☐ Azathioprine	☐ Sulfasalazine	☐ Cyclosporine	☐ Etanercept	☐ Enbrel	☐ Hydroxycloroquine/Plaquenil
☐ Infliximab	☐ Remicade	☐ Humira	☐ Adalimumab	☐ Estrogen	☐ Alendronate
☐ Fosamax	☐ Residronate	☐ Actonel	☐ Etidronate	☐ Didronel	☐ Raloxifene
☐ Evista	☐ Forteo	☐ Calcitonin- Injection or nasal		☐ Probenecid	☐ Colchicine ☐ Allopurinol

Antidepressants:_____

Why were the medications stopped? (Specify)_____

Do you take calcium? Y__ N_____ Which Kind?_____ How much per day?_____

Which vitamin do you take:_____

Have you taken prednisone? Y___ N_____ How Long?_____ Range of doses?_____

Have you tried any complementary medications (e.g glucosamine) YN_____ Please list all of them:

_____

Have you had physical therapy? Y N_____ When?_____

Any other therapies? (e.g chiropractor, magnets, massage, acupuncture, other) Y____ N_____.

Any other comments?

_____

_____

_____