

# RHEUMATOLOGY CLINIC OF UTAH – PATIENT INFORMATION FORM

Please Print Clearly and Fill Out Completely

Patient Name \_\_\_\_\_  
Last Name First Name M.I. Maiden

Mailing Address \_\_\_\_\_  
Street City State Zip

Home Phone ( ) \_\_\_\_\_  
Work Phone ( ) \_\_\_\_\_  
Cell Phone ( ) \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_

Physician who sent you (First & Last Name) \_\_\_\_\_

Primary Care Physician (First & Last Name) \_\_\_\_\_

Gender -  Male  Female

Marital Status \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

SSN# \_\_\_\_\_

Preferred Language (if not English) \_\_\_\_\_

## PARENT or RESPONSIBLE PARTY (if patient is under the age of 18 or under the guardian care of a third party)

Name \_\_\_\_\_  
Last Name First Name M.I. Maiden

Address \_\_\_\_\_  
Street City State Zip

Home Phone ( ) \_\_\_\_\_  
Work Phone ( ) \_\_\_\_\_  
Cell Phone ( ) \_\_\_\_\_

Patient's Relationship to the Responsible Party \_\_\_\_\_

Gender -  Male  Female

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

SSN# \_\_\_\_\_

Employer \_\_\_\_\_

Employment Status -  Full-time or  Part-time

Other Parent's Name \_\_\_\_\_

## INSURANCE INFORMATION (Despite our scanning your insurance card, please fill in all fields)

### Primary Insurance:

Insurance Company \_\_\_\_\_  
Ins. Address \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_  
Subscriber's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Subscriber's ID# \_\_\_\_\_  
Group# \_\_\_\_\_  
Patient's Relationship to Subscriber \_\_\_\_\_

### Secondary Insurance:

Insurance Company \_\_\_\_\_  
Ins. Address \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_  
Subscriber's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Subscriber's ID# \_\_\_\_\_  
Group# \_\_\_\_\_  
Patient's Relationship to Subscriber \_\_\_\_\_

## EMERGENCY CONTACT (Not living with you)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_

**RELEASE OF MEDICAL INFORMATION** – By signing below, I authorize the doctors and staff at the Rheumatology Clinic and its affiliates to disclose my protected health information, including but not limited to office notes, diagnostic tests, and lab results, to the below-named persons (e.g., spouse or parent). This authorization shall be effective until I revoke it in writing.

Individual #1 \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Individual #2 \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**FINANCIAL POLICY & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES** – I am responsible, regardless of insurance coverage, for payment of all rendered services. I am responsible for copayments, deductible amounts, co-insurance, non-covered services, or services deemed as “non-medically necessary” by my insurance carrier. **I understand co-payments are due at time of service.** I am responsible for providing correct/updated insurance information so this office can bill my insurance. I understand that interest will accrue on all amounts 30 days and older at the rate of 18% annually until paid in full. If any amounts are referred to a third party collection agency, I am responsible for a collection fee of up to 40% of the principal amounts owing as allowed by Utah Code Annotated, sec. 12-1-11 in addition to any other amounts, such as interest or court costs. **I understand that some medical services performed in the office (ultrasounds, joint aspirations, etc.) are billed separately from the office visit.**

By signing below, I acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices. Furthermore, I have read the Financial Policy above and agree to abide by its guidelines.

\_\_\_\_\_  
Patient or Patient's Representative Signature

\_\_\_\_\_  
Date

If signed by Representative, state name of: Representative \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

# PATIENT MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: \_\_\_\_\_

Date symptoms started: \_\_\_\_\_

Primary reason for visit: \_\_\_\_\_

## MEDICAL HISTORY *(check all that apply)*

- Asthma
- Cancer *(list type)* \_\_\_\_\_
- Colitis
- Hepatitis
- HIV/AIDS
- Iritis
- Psoriasis
- Rheumatic Fever
- Seizures
- Stroke
- Thyroid Disease
- Tuberculosis
- Ulcers
- Uveitis
- Venous Thrombosis

## LIST ALL DIAGNOSED MEDICAL CONDITIONS

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## LIST ALL PREVIOUS SURGERIES:

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Preferred Pharmacy: \_\_\_\_\_  
*(Name, City)*

## SOCIAL HISTORY *(check all that apply)*

- Alcohol use: \_\_\_\_\_ drinks per week       No Alcohol use
- At risk for HIV infection (unprotected sex, IV drug use, history of blood transfusions)
- History of drug use
- Smoking Status:  Current    If current: \_\_\_\_\_ packs per day  
 Former (when quit: \_\_\_\_\_)       Never smoked
- Second hand smoke exposure:  
 Environmental     Occupational     Perinatal/before birth
- Tobacco use (other/chew): \_\_\_\_\_

## FEMALE PATIENTS ONLY:

Number of miscarriages: \_\_\_\_\_

## LIST CURRENT MEDICATIONS & SUPPLEMENTS:

*(use back of this form for more space)*

Name	Dose	Frequency	Route

## LIST ALLERGIES TO MEDICATIONS:

No Known Allergies

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## FAMILY HISTORY *(check if blood relatives have the following)*

DISEASE	RELATIONSHIP TO YOU
<input type="checkbox"/> Ankylosing Spondylitis	_____
<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Blood Clots	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Colitis	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Hypertension	_____
<input type="checkbox"/> Iritis	_____
<input type="checkbox"/> Liver Disease	_____
<input type="checkbox"/> Lupus	_____
<input type="checkbox"/> Osteoarthritis	_____
<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Psoriasis	_____
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Reactive Arthritis	_____
<input type="checkbox"/> Rheumatoid Arthritis	_____
<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Uveitis	_____

## REVIEW OF SYSTEMS

PLEASE CIRCLE 'YES' or 'NO' FOR ALL ITEMS BELOW  
(Problems you have had within the past 3 months)

### ALLERGY/IMMUNE

Yes No Hayfever  
Yes No Swollen glands or nodes  
Yes No Weak immune system

### CARDIOVASCULAR

Yes No Chest pain  
Yes No High blood pressure  
Yes No Palpitation or heart racing  
Yes No Swelling in legs or feet

### EARS

Yes No Ear aches  
Yes No Ear infections  
Yes No Hearing problems  
Yes No Tinnitus  
Yes No Vertigo

### ENDOCRINE

Yes No Breast discharge  
Yes No Diabetes  
Yes No Excessive thirst  
Yes No Heat or cold intolerance  
Yes No Thyroid problems

### EYES

Yes No Blurry vision  
Yes No Double vision  
Yes No Glasses or contacts  
Yes No Glaucoma

### GENERAL

Yes No Fatigue  
Yes No Fever  
Yes No Loss of appetite  
Yes No Night sweats  
Yes No Recent weight change

### GASTROINTESTINAL

Yes No Abdominal pain  
Yes No Blood in stool  
Yes No Constipation  
Yes No Diarrhea  
Yes No Difficulty swallowing  
Yes No Heartburn  
Yes No Nausea or vomiting

### GENITOURINARY

Yes No Blood in urine  
Yes No Frequent urination  
Yes No Kidney stones  
Yes No Loss of bladder control

### HEMATOLOGIC/LYMPH

Yes No Anemia  
Yes No Blood transfusions  
Yes No Easy bruising or bleeding

### INTEGUMENTARY (Skin)

Yes No Changes in hair or nails  
Yes No Dryness  
Yes No New stretch marks  
Yes No Rashes

### MOUTH and THROAT

Yes No Dry mouth  
Yes No Frequent sore throats  
Yes No Sore tongue

### MUSCULOSKELETAL

Yes No Back pain  
Yes No Muscle cramps  
Yes No Muscle weakness  
Yes No Neck pain  
Yes No Swelling or pain in joints

### NEUROLOGIC

Yes No Frequent headaches  
Yes No Head injury  
Yes No Loss of consciousness  
Yes No Numbness around mouth  
Yes No Numbness or tingling  
Yes No Seizures  
Yes No Tremors

### NOSE and SINUSES

Yes No Frequent colds  
Yes No Nasal stuffiness  
Yes No Sinus troubles

### PSYCHIATRIC

Yes No Anxiety  
Yes No Depression

### RESPIRATORY

Yes No Asthma  
Yes No Frequent cough  
Yes No Shortness of breath  
Yes No Spitting up blood  
Yes No Wheezing

I have reviewed the above and circled all symptoms which apply.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_