Arthritis, Rheumatic & Back Disease Associates

Dear _____,

We are looking forward to seeing you on _____.

Your appointment with Dr. _____ has been set aside especially for you and includes time for us to answer any questions you may have. To help us with your visit, please be sure to arrive at your appointment with all of the following items:

- ☐ Completed forms enclosed in this packet.
- ☐ ALL insurance cards. IF YOU HAVE ONLY BEEN ISSUED A DIGITAL COPY OF YOUR INSURANCE CARD, PLEASE MAKE SURE YOU BRING A PRINTED COPY OF THE CARD TO YOUR APPOINTMENT.
- ☐ If needed, a current referral for your visit.
- ☐ A list of your current medications.
- ☐ Reports on recent laboratory tests, if applicable.
- ☐ Reports on recent X-rays or other imaging tests, if applicable.
- ☐ Reports on your most recent bone density scan (DXA), if applicable.

If for any reason you are unable to keep this appointment, we require 48 hours notice to avoid a missed appointment charge of $75. Thank you for the trust and confidence you have placed in us to provide your medical care.

Sincerely,

Sheldon D. Solomon, M.D., F.A.C.P.
James P. Dwyer, D.O., M.B.A.
Adrienne R. Hollander, M.D.
Arielle S. Silver, M.D.

Michael C. Schuster, M.D., Ph.D.
Amy M. Evangelisto, M.D.
Alicia Weeks, M.D.
Joshua Sundhar, M.D.
Janet Krommes, M.D.

Neha Patel, M.D.
Shawn Abraham, M.D.
Carrie Edelman, M.D.
Nancy Eisenberger, N.P.

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VOORHEES
The Pavilions of Voorhees
2301 E. Evesham Road,
Building 800, Suite 115
Voorhees, NJ 08043
Phone: (856) 424-5005
Fax: (856) 424-4716

MOORESTOWN
The Pavilions at Moorestown
740 Marne Hwy S.
Suite 102
Moorestown, NJ 08057
Phone: (856) 424-5005
Fax (856) 235-0201

SEWELL
Washington Pavilions
100 Kings Way East
Unit B-1
Sewell, NJ 08080
Phone: (856) 424-5005
Fax (856) 740-0369

HAMILTON
The Professional Center
2123 Klockner Road
Hamilton, NJ 08690
Phone: (856) 424-5005

GALLOWAY
314 Chris Gaupp Drive
Suite 102
Galloway, NJ 08205
Phone: (856) 424-5005

WALL
Brielle Professional Park
2640 Highway 70, Building 11
Wall, NJ 08736
Phone: (856) 424-5005

Revised: 5/2/2018

Arthritis, Rheumatic & Back Disease Associates

PATIENT INFORMATION

Patient name:		Date of birth:	Gender: ☐ M ☐ F
Street:		Last 4 digits of Social Security #:	
City:	State/ZIP:	Home phone:	
E-mail:		Cell or business phone:	
Insurance subscriber name:		Subscriber date of birth:	Relationship to subscriber (e.g. self, child, spouse):
Emergency contact name:		Emergency contact phone:	
Are you required to have a referral from your Primary Care Physician to see a specialist? ☐ Yes ☐ No		Primary Care Physician name and phone:	

PRIMARY INSURANCE		**SECONDARY OR SUPPLEMENTAL INSURANCE**	
Insurer name:		Insurer name:	
Address and phone:		Address and phone:	
Patient ID #:	Group #:	Patient ID #:	Group #:
Effective date:		Effective date:	
If applicable, what is your copay for specialist office visits?			

PHARMACY

If you have pharmacy benefits, are they covered by your Primary Insurance? ☐ Yes ☐ No		If not, what are the name, address, and phone of your pharmacy insurance carrier?
Pharmacy benefit ID #:	Effective date:	
Local pharmacy: Name, address, and phone		Mail order pharmacy: Name, address, and phone

IMPORTANT: Many health insurance policies have specific restrictions as to the health care they cover and where that care can be given. Our office will try to provide to your insurance company information that will maximize your coverage. It is important, however, that you be informed about your coverage. BEFORE YOUR VISIT TO OUR OFFICE please refer to your insurance card and the telephone number on the reverse side, your employer benefits manager, or insurance agent to answer the following questions:

1. Are you limited in your choice of physicians? ☐ Yes ☐ No
2. If you need lab, x-rays, or other therapy are there only certain places where these can be performed? ☐ Yes ☐ No
3. Are there only certain hospitals to which you can be admitted? ☐ Yes ☐ No

This will help you, and us better understand any restrictions you may have on your health care coverage. If you are unsure of the answers to these questions, please call your employer benefits manager or your insurance company. A phone number for your insurance company appears on the back side of your card.

Arthritis, Rheumatic & Back Disease Associates

PLEASE COMPLETE & BRING WITH YOU TO YOUR APPOINTMENT

Last Name	First	Middle	
Birth Date	Birth Place	Gender ☐ M ☐ F	Marital Status
Race: ☐ American Indian or Alaska Native ☐ Asian	☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Address		Language(s) spoken	
Home Phone #	Other Phone #	Occupation	
Emergency Contact Name	E.C. Relationship	E.C. Phone #	
Date of Last Physical Exam	Doctor		
Referring Doctor	Referring Doctor's Address		

Have you had any of the following: (circle ALL that apply)

Stroke	Psoriasis	Osteopenia / Osteoporosis	Frequent Urinary Tract Infection
Cancer	High Blood Pressure	Heart Attack	Angina (Chest Pain)
Tuberculosis	Kidney Disease	Congestive Heart Failure	High Cholesterol
HIV/AIDS	Kidney Stone	Seasonal Allergies	Enlarged Prostate
Diabetes	Phlebitis	Thyroid Disease	Anxiety
Leukemia	Colitis	Fibromyalgia	Depression
Seizures	Stomach Ulcers	Gout	Other Mental Illness
Migraines	Diverticulitis	Rheumatoid Arthritis	Suicide Attempt
Asthma / Emphysema	Irritable Bowel Disease	Osteoarthritis	History of Blood Transfusions
Bleeding Disorder	Rheumatic Heart Disease	Lupus (Systemic)	Spinal Stenosis
Liver Disease / Hepatitis	Congenital Heart Disease	Psoriatic Arthritis	Herniated Disc

Have you had other prior medical problems not mentioned above? ☐ **NO CHRONIC MEDICAL ISSUES**

List any SURGERY you have had and the years in which you had them. ☐ **NO HISTORY OF SURGERY**

List any DRUG ALLERGIES: ☐ **NO DRUG ALLERGIES**

List all CURRENT MEDICATIONS (including eye drops): ☐ **NO CURRENT MEDICATIONS**

List any prior arthritis drugs you've tried:

Do you currently smoke?	Y N	Do you currently drink alcohol?	Y N
If no, have you smoked in the past?	Y N	If no, did you drink in the past?	Y N
		If yes, how much alcohol do you consume daily?	
Do you currently use, or have you used in the past, IV drugs, marijuana, heroin, or cocaine?	Y N	Do you have a living will or advanced directives?	Y N

Have you RECENTLY had any of the following (Circle Y or N):

Fatigue	Y N	Trouble swallowing	Y N	Heartburn	Y N	Rash from the sun	Y N
Weight loss	Y N	Hoarseness	Y N	Diarrhea	Y N	Other skin condition	Y N
Dry Eyes	Y N	Chest pain	Y N	Constipation	Y N	Headache	Y N
Eye pain	Y N	Rapid heart beat	Y N	Black or bloody stool	Y N	Dizziness	Y N
Red eyes	Y N	Shortness of breath	Y N	Burning when urinate	Y N	Numbness in hands	Y N
Ringing in ears	Y N	Cough	Y N	Blood in urine	Y N	Depression	Y N
Nose bleeds	Y N	Wheezing	Y N	Color change in fingers when exposed to cold			Y N
Dry mouth	Y N	Coughing up blood	Y N	Hair loss	Y N	Excessive worry	Y N
Mouth sores	Y N	Frequent Stomach pain	Y N	Psoriasis	Y N	Trouble Sleeping	Y N

To be answered by women only:

Are you post-menopausal?	Y N	Date of last menstrual period:	
Are you currently taking oral contraceptives?	Y N	How many children born alive?	
Have you ever had any complications of pregnancy?	Y N	How many miscarriages?	

Family history

	Name	Gender	If living		If deceased	
			Age	Medical issues	Age at death	Cause/Prior medical issues
Father		M				
Mother		F				
Siblings		M F				
		M F				
		M F				
		M F				
Spouse		M F				
Children		M F				
		M F				
		M F				
		M F				

Briefly describe what brings you to the office today.

Is there any additional information you feel is important and may impact your health/medical care?

Are you interested in participating in a Clinical Trial that could provide a new treatments for your disease? ☐ Yes ☐ Not Now

Revision: 4/12/2018

Arthritis, Rheumatic & Back Disease Associates

This form must be completed and signed by the patient or legally authorized representative.

INSURANCE AUTHORIZATION

I request that payment of authorized medical benefits is made on my behalf directly to the Arthritis, Rheumatic & Back Disease Associates (ARBDA) provider of services furnished to me. I authorize the release of any medical information needed to process my health insurance claim to my health insurance carrier or its agents.

PAYMENT GUARANTEE

I guarantee payment of all charges related to all services provided to me by ARBDA from my first date of examination or treatment. I understand that charges for my services will be submitted to my health insurance carrier for payment, and that all charges not covered by my insurance plan, including but not limited to deductible amounts and co-payments, are my responsibility. In the event that I fail to make full payment or fail to comply with other payment arrangements made with ARBDA's approval, I understand that appropriate collection measures may be taken.

If my ARBDA provider does not participate in my insurance plan, charges for my services will still be submitted to my insurance carrier, but I understand that any and all charges not covered by my plan as a result of my provider's non-participation are my responsibility.

I understand that if my insurance company requires a current, valid referral for services, and if I do not have a current, valid referral on file the day my services are provided, then I am responsible for all charges.

I may request a list of charges incurred for my care at any time.

CONSENT TO OBTAIN MEDICATION HISTORY

With your consent, we may request and use your prescription medication history information using the e-prescription feature of our electronic medical records. This is only for informational purposes so that an up to date record of your medication is available for your treatment and safety.

☐ Yes, I give my consent to obtain my medication history using the e-prescribing feature.

☐ No, I do not give my consent to obtain my medication history using the e-prescribing feature. I understand that my mediation information may not be complete when making treatment decisions.

NOTICE OF PRIVACY PRACTICE

I have been advised that ARBDA complies with required privacy regulations regarding my Individually Identifiable Health Information created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of ARBDA's Notice of Privacy Practices is available for me if I want one.

Printed name of patient or authorized representative	Signature of patient or authorized representative	Date

Arthritis, Rheumatic & Back Disease Associates

POLICY ON LEGAL CASES, TESTIMONY, AND DISABILITY FORMS

ARBDA does not accept new patients for the purpose of examination to support legal cases, testimony, or disability claims forms. We believe these activities detract from our primary responsibility, which is to deliver the highest quality medical care. We are always able to forward your office records to requesting parties approved by you. If you have questions regarding this policy, please discuss them with us.

NOTICE OF NONDISCRIMINATION

Arthritis, Rheumatic & Back Disease Associates, P.A. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Arthritis, Rheumatic & Back Disease Associates, P.A. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Arthritis, Rheumatic & Back Disease Associates, P.A.:

- Can provide aids and services to people with disabilities to communicate effectively with us.
- Can provide language services to people whose primary language is not English.

If you need these services, contact Elaine Piontkowski, Director of Human Resources.

If you believe that Arthritis, Rheumatic & Back Disease Associates, P.A. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Human Resources Department.

Patient History/RAPID 3

Date: _____ Patient Name: _____

Weight: _____ lbs Height: _____ inches

Reason for Today's Visit: _____

1. Please circle the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of a car, bus, train, or airplane?	0	1	2	3
i. Walk two miles or three kilometers, if you wish?	0	1	2	3
j. Participate in recreational activities and sports as you would like, if you wish?	0	1	2	3

2. How much pain have you had because of your condition OVER THE PAST WEEK? Circle one.

No pain 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 Severe pain

3. Considering all the ways in which illness and health conditions affect you at this time, how are you doing?

Best 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 Worst

4. Past History: Have there been any changes since last visit?

☐ New illness/treatment ☐ Operations ☐ Injuries ☐ medications ☐ No change

5. Family /Social History: Please list any family social or occupational changes since last visit.

1. FN (0-10) ☐

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

2. PN (0-10) ☐

4. PTGL (0-10) ☐

RAPID 3 (0-30) ☐

CONVERSION TABLE

Near Remission (NR): 1=0.3; 2=0.7; 3=1.0
Low Severity (LS): 4=1.3; 5=1.7; 6=2.0
Moderate Severity (MS): 7=2.3; 8=2.7; 9=3.0; 10=3.3; 11=3.7; 12=4.0
High Severity (HS): 13=4.3; 14=4.7; 15=5.0; 16=5.3; 17=5.7; 18=6.0; 19=6.3; 20=6.7; 21=7.0; 22=7.3; 23=7.7; 24=8.0; 25=8.3; 26=8.7; 27=9.0; 28=9.3; 29=9.7; 30=10.0

OFFICE USE ONLY. Physician Assessment of Disease Activity:

Very well 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 Very poorly

Reviewed with Patient: _____ Date: _____