Texas Arthritis and Rheumatology Specialists
Patient Registration Form

Welcome to Our Practice

Date: __________________

Patient Name: _______________________________________ Date of Birth: ______________
Street Address: ____
City: __________________________ State: ______ Zip: ________ Sex: M F (circle)
Home Phone #: _________________________
Work Phone #: _________________________ Cell Phone # _____________________
Social Security Number: ________________________
Email address:____

Marital Status: (circle) Single Married Divorced Widowed
Spouse's Name: ____
Spouse's Date of Birth: ____

Do you have health insurance? (circle) Y N
Please make sure that you provide the receptionist with your insurance cards to obtain copies.
The name of your insurance company: ____
The name as it appears on your insurance card: ____
Who is the policy holder (subscriber) of the insurance? ____

Policy Number: ______________________ Group Number: ______________________

Medicare Number (if applicable): _____________ Medicaid Number (if applicable): ____________

Emergency Contact: ______________________ Phone # ________________________________

With whom may we share financial information about your account? (Provide Name and Birth date)
____
____
____

With whom may we share health information about you? (Provide Name and Birth date)
____
____
____

How were you referred to our practice? (circle)
Physician, if so, name: ____
Friend/relative, if so, name: ____
Yellow pages Newspaper KLTV Hospital referral Website

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with the insurer).

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signature: _____________________________________ Date: ___________________

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Health History

Name: ____

Address: ____

Date of Birth: ________________________ Phone: ___________________________

Marital Status: _______________________ Referring Doctor: ____________________

(Ladies) Number of Pregnancies/Children: ______________________________________

Reason for This Visit: ____

Medical Conditions:	Surgeries:
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

Medical Conditions that Run in Your Family:

Rheumatoid Arthritis? _____ Psoriasis? _____ Lupus? ________

____

Medications (Dosage and frequency):

____

____

____

____

____

____

Medication Allergies: ____

Have you had any of the following symptoms recently? Please Circle and Explain

Weight Gain/Loss	Eyes: ________________________________
Fever	Ears/Nose/Throat: ______________________
Rash	Cardiac: ______________________________
Psoriasis	Respiratory: ___________________________
Pleurisy	Allergic Symptoms: ______________________
Hair falling out	Gastrointestinal: ________________________
Cold/blue fingers	Urinary: ______________________________
Dry mouth/Eyes	Neurologic: ____________________________
Alcohol Use Y/N	Muscular: _____________________________
Drinks/week _______	Fatigue: ______________________________
Tobacco Use Y/N	Hormonal: _____________________________
# Packs/day _______	Psychiatric: ____________________________

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Patient Assessment

Considering all the ways in which illness and health conditions may affect you at this time, please make a mark below to show how you are doing:

Very Well I———————————————————————————I Very Poorly

How much pain have you had because of your condition over the past week? Place a mark on the line below to indicate how severe your pain has been:

No Pain I———————————————————————————I Pain as bad it can be

Please answer the following questions, even if you feel that they may not be related to you at this time. Answer exactly as you think or feel—there are not right or wrong answers. Check the one best answer for each question.

Activity Level

Right now, are you able to:

	Without Any Difficulty	**With Some Difficulty**	**With Much Difficulty**	**Unable To Do**
1. Dress yourself, including tying shoelaces and doing buttons?	________	________	________	________
2. Get in and out of bed?	________	________	________	________
3. Lift a full cup or glass to your mouth?	________	________	________	________
4. Walk outdoors on flat ground?	________	________	________	________
5. Wash and dry your entire body?	________	________	________	________
6. Bend down to pick up clothing from the floor?	________	________	________	________
7. Turn regular faucets on and off?	________	________	________	________
8. Get in and out of a car, bus, train or airplane?	________	________	________	________
9. Walk two miles?	________	________	________	________
10. Participate in sports and games as you like?	________	________	________	________
11. Get a good night's sleep?	________	________	________	________
12. Deal with feeling of anxiety or being nervous?	________	________	________	________
13. Deal with feelings of depression or feeling blue?	________	________	________	________

Your Name: ________________________________ **Today's Date:** ________________ **Time of Day:** __________

Texas Arthritis and Rheumatology Specialists

Assignment of Benefits

Patient Name: ____

Date of Birth: ______________________ Social Security Number: ______________________

Patient Authorization/Signature on File

I hereby authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me.

I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Consent To Treatment

I voluntarily consent to receive medical and health care services provided by Texas Arthritis, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this consent to treatment will be valid and remain in effect as long as I attend Texas Arthritis, unless revoked by me in writing.

Financial Responsibility and Assignment of Benefits

In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance, Medicare/Medicaid, or other third party payor benefits for medical or health care services payable to me, be payable to the providers of Texas Arthritis. I also authorize direct payments to the total amount of my medical and health care charges, to the providers of Texas Arthritis. I certify that the information I have provided in connection with any application for payment by third party payors, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by or which exceed the estimated amount to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third party payor and agree to make payment as requested by Texas Arthritis.

Notice of Patient Responsibilities

I acknowledge that the Notice of Patient Responsibilities has been made available to me.

HIPAA Notice of Patient Privacy Practices

I acknowledge that the HIPAA Notice of Patient Privacy Practices has been made available to me.

______________________________ ______________________________

Patient/Other Legally Authorized Person Witness

______________________________ ______________________________

Printed Name and Relationship to Patient Date

Meaningful Use Questionnaire

(Federal government requires that we collect this information)

Patient Name :____DOB:___________

The language I speak is primarily: _______________

Race :

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Black / African American
- ☐ Hispanic / Latino
- ☐ Native Hawaiian / Pacific Islander
- ☐ White / Caucasian

My Preferred Retail Pharmacy is:

Pharmacy Name: _____________________________________

Address: _____________________________________

____

Phone Number: _____________________________________

My Preferred mail order pharmacy is: (if applicable)

Pharmacy Name: _____________________________________

Phone Number: _____________________________________

GLEN GRAVES MD
LUIS VASQUEZ MD
903-561-9255 PHONE
903-561-0034 FAX

REQUEST FOR RELEASE OF MEDICAL RECORDS

DOCTOR INFORMATION:____

PHONE NUMBER:________________________FAX NUMBER:________________________

ADDRESS:____

CITY, STATE, ZIP:____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:

NAME: DR. GLEN GRAVES DR. LUIS VASQUEZ

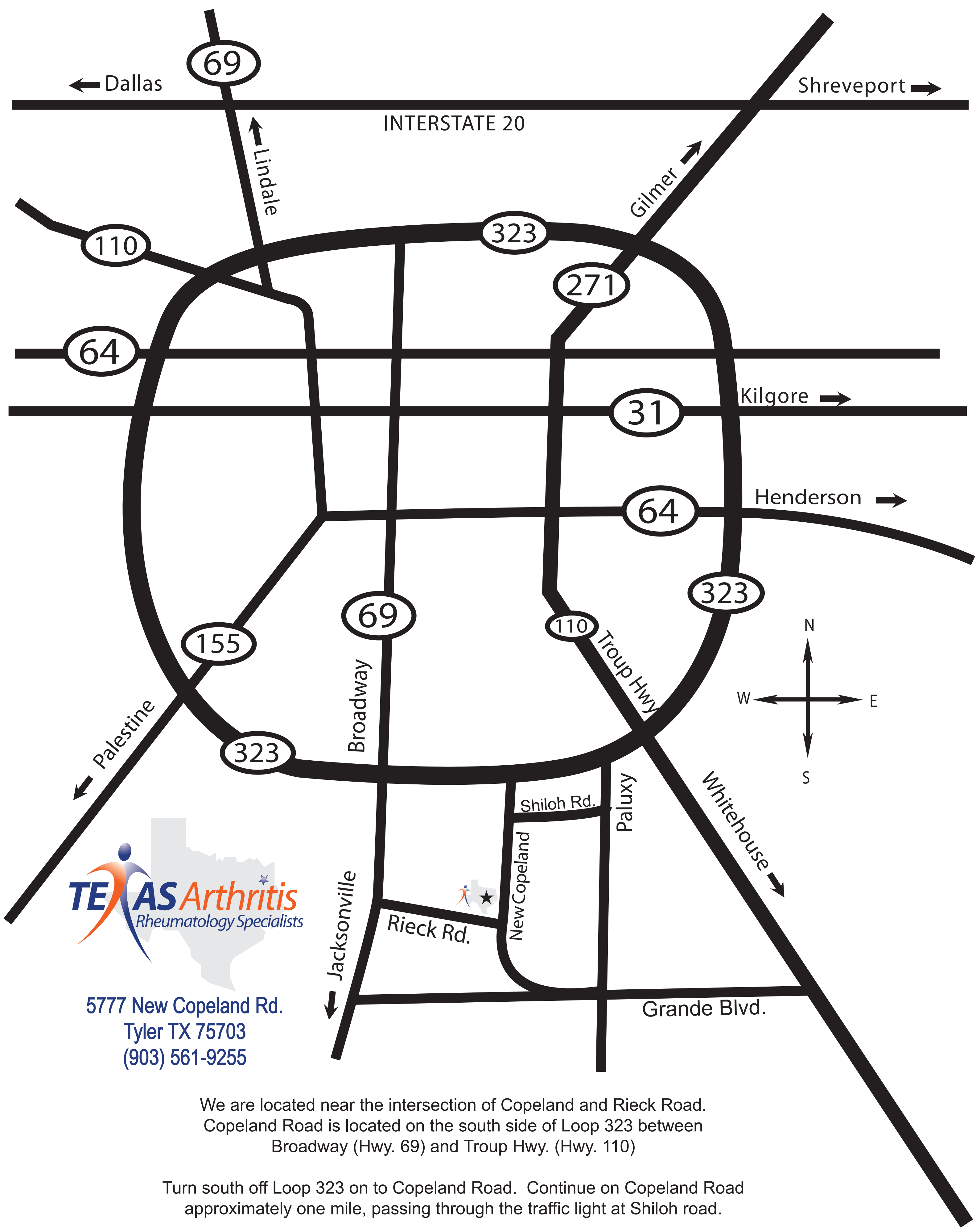
ADDRESS: 5777 NEW COPELAND ROAD, TYLER, TEXAS, 75703

PHONE: 903-561-9255 **FAX:** 903-561-0034

PATIENT'S NAME: ____

DATE OF BIRTH: ____

PATIENT'S SIGNATURE: ____



We are located near the intersection of Copeland and Rieck Road.
Copeland Road is located on the south side of Loop 323 between
Broadway (Hwy. 69) and Troup Hwy. (Hwy. 110)

Turn south off Loop 323 on to Copeland Road. Continue on Copeland Road
approximately one mile, passing through the traffic light at Shiloh road.

Our building is located on the right (before the traffic light at Rieck Road)