texas arthritis
RHEUMATOLOGY SPECIALISTS

Patient Registration Form

Welcome to Our Practice

Date: _____

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Legal Sex: ☐Male ☐Female

Home Phone #: _____

Work Phone #: _____ Cell Phone # _____

Social Security Number: _____

Email address:_____

Marital Status: (circle) ☐ Single ☐ Married Divorced ☐ Widowed

Spouse's Name: _____ Date of Birth: _____

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)

_____

_____

_____

Primary Care Physician: _____

How were you referred to our practice? (circle)
Physician, if so, name: _____
Friend/relative, if so, name: _____
Yellow pages Newspaper Television Internet Facebook Insurance Hospital referral

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: _____.

Patient Name: _____ DOB: _____

Health History

(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
Fever
Rash
Psoriasis
Pleurisy
Hair falling out
Cold/blue fingers
Dry mouth/Eyes
Alcohol Use Y/N
Drinks/week _____
Tobacco Use Y/N
Packs/day _____

Eyes: _____
Ears/Nose/Throat: _____
Cardiac: _____
Respiratory: _____
Allergic Symptoms: _____
Gastrointestinal: _____
Urinary: _____
Neurologic: _____
Muscular: _____
Fatigue: _____
Hormonal: _____
Psychiatric: _____

Patient Name: _____ DOB: _____

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: _____

Patient Name: _____ DOB: _____

PATIENT FINANCIAL & PAYMENT POLICY

Do you have health insurance? ☐Yes ☐No

Please make sure that you provide the receptionist with <u>ALL</u> your insurance cards to obtain copies.

Primary Insurance: _____ ID: _____

Subscriber's Name: _____
First MI Last

Relationship to Policy Holder:
☐Spouse ☐Father ☐Mother ☐Other (please Specify) _____ DOB: _____

☐ Same as Patient Information (If different, please complete section below)

Subscriber's Name: _____
First MI Last

Address: _____
Street Apt # City State

Employer Name: _____

Secondary Insurance: _____ ID: _____

Subscriber's Name: _____
First MI Last

Relationship to Policy Holder:
☐Spouse ☐Father ☐Mother ☐Other (please Specify) _____ DOB: _____

☐ Same as Patient Information (If different, please complete section below)

Subscriber's Name: _____
First MI Last

Address: _____
Street Apt # City State

Employer Name: _____

Have you been admitted as an inpatient at a **Hospital Facility, Rehab Facility, Skilled Nursing Facility** in the 30 days? Facility Name: _____ Date released: _____

Patient Name: _____ DOB: _____

Texas Arthritis & Rheumatology accepts Medicare Part B and Medicaid (secondary to traditional Medicare). These payers have time limits in place that make it crucial for us to be fully informed of your Medicare Part B and Medicaid statuses. Please complete the following information:

Medicare Part B

Patient SSN#: _____

Are you currently covered under Medicare Part B*? : ☐ Yes ☐ No
*If you are unsure, please request assistance from our office staff.

If yes, what is your Medicare ID#: _____

Is Medicare Part B ☐ Primary ☐ Secondary
*If you are unsure, please request assistance from our office staff.

If secondary, who is your Primary Insurance: _____

PLEASE PRESENT YOUR MEDICARE CARD TO THE FRONT DESK TO BE SCANNED INTO YOUR FILE.

Medicaid

Are you currently covered under Medicaid*? : ☐ Yes ☐ No
*If you are unsure, please request assistance from our office staff.

If yes, what is your Medicaid ID#: _____

PLEASE PRESENT YOUR MEDICAID CARD TO THE FRONT DESK TO BE SCANNED INTO YOUR FILE.

I _____ verify that the information above is true and complete. I understand that if I withhold information about my insurance coverage I may be held financially responsible for charges that are no longer billable to insurance. I understand that if my insurance changes at any time I am to notify Teas Arthritis & Rheumatology immediately to ensure accurate and prompt billing to my insurance.

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**. I further understand that all amounts are due upon request and are payable to **Texas Arthritis**. I understand that should my account become delinquent, I shall pay the reasonable collection and attorney's fees of **Texas Arthritis**, if any.

_____ _____
Patient Name Date

Patient Name: _____ DOB: _____

PATIENT CONSENT

Patient Authorization/Signature on File

_____ initial

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 remaining balance that is not covered by my insurance company, Medicare and/or supplemental policy. A copy of this signature is as valid as the original. I understand that by not signing this consent, the patient will not be provided medical care except in case of emergency.

Consent To Treatment

_____ initial

I authorize **Texas Arthritis**, employees and such associates, including physician assistants, and other health care providers to provide healthcare services as my physicians deem necessary for diagnosis and/or treatment. 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.

_____ initial

I consent to treatment by a Physician Assistant that work closely with our Physicians during my course of care at Texas Arthritis.

_____ initial

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.

Consent for Photos

_____ initial

I understand that during the course of treatment, photographs may be taken for clinical and educational purposes. No audio taping, videotaping, or photography is allowed by non-staff members.

Consent For Filing Insurance Claims

_____ initial

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.

Consent For Electronic Prescription History

_____ initial

I understand that to offer the best patient care, **Texas Arthritis** will retrieve my prescription history that has been ordered and filled through an HER system. I authorize **Texas Arthritis** to import the prescription history obtained through an HER system into my electronic chart.

Consent For Appointment Reminders / Third Party Communications

_____ initial

I authorize **Texas Arthritis** to send me appointment reminders via automated SMS text messages, phone calls, emails, and additional information regarding rheumatology, including health-related products or services and quality of care surveys provided by **Texas Arthritis**. I understand the message/data rates may apply to messages sent by **Texas Arthritis** under my cell phone plan. I authorize **Texas Arthritis** and third-party collection agents to utilize all contact information I have provided in efforts to communicate regarding my account. I agree that affiliates may contact me through text messages, ring=less calls, and emails to provide me with my bill and to remind me to pay for services provided by **Texas Arthritis**, in compliance with federal and state laws. I understand that I am under no obligation to receive automated notifications and may opt-out of these communications at any time by following the prompts in the reminder. Further, I revoke my consent to receive any and all communications.

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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
(CIRCLE ONE) TO / FROM:

NAME: DR GLEN GRAVES DR LUIS VASQUEZ

ADDRESS: 5777 NEW COPELAND ROAD,
SUITE 100
TYLER, TEXAS 75703
PHONE: 903.561.9255
FAX: 903.561.0034

PATIENT'S NAME:_____

DATE OF BIRTH:_____

PATIENT'S SIGNATURE:_____