7300 HANOVER DRIVE #201
GREENBELT, MD 20770

9131 PISCATAWAY ROAD #310
CLINTON, MD 20735

ARTHRITIS AND PAIN ASSOCIATES OF P.G. COUNTY
PHONE (301) 345-5600
FAX (301) 345-7715
WEBSITE - WWW.ARTHRITISPAINPG.COM

DR. JONATHAN ADELSON - DR. DONALD THOMAS - DR. YEVGENIY SHEYN - DR. RUKMINI KONATALAPALLI - DR. MARIA CHOU
MARIA CUADRA, PA-C - CHIKAKO RIESTER, CRNP

Welcome,

**** Please arrive 45 mins - 1 hour early to allow our staff time to register you into our computer So you are ready for your doctor on your appointment time. *****

Thank you for choosing our office to provide you with Rheumatological care. Our goal is to deliver Quality and Efficient care to you and your family members

Office and Telephone Hours

Our office hours are Monday thru Friday 7:00 am – 3:00 pm. Phone calls are welcome. Our telephone hours are from 7:00 am – 3:30 pm. **Phones will be answered during our lunch hour 12:00 pm – 1:00 pm.** We have 3 Telephone Receptionists that will answer your call. If the lines are busy and you are directed to our voice mail, please: speak clearly and leave your name and number and reason for your call. One of our staff will get back to you by the end of the day or next business day.

Insurance Requirements

All HMOs require that you, as the patient, bring in a written referral to our office in order for us to see you. HMOs require referrals from your primary care physician for all visits & bone density x-ray testing. Cigna and Aetna may use electronic referrals. However, we still need to verify that you have a current referral on file. Problems with referrals occur daily: If you do not have a referral when you come in for your appointment, you have two choices:

1. Reschedule your appointment
2. Leave us a check-cash-Visa-MC-Discover Payment for the amount of the visit.

All co-pays are required at the time of your visit.

List of insurances we accept*: HMO'S NEED REFERRALS*

AETNA US HEALTHCARE HMO & PPO, MEDICARE PART B, BLUE SHIELD OF DC (CAREFIRST), NCPPO
BLUE SHIELD OF MD (CAREFIRST), ONE NET PPO, BLUE SHIELD OF MD POS, GEHA (ONE NET PPO)
BLUE CHOICE(NEEDS REFERRAL), TRICARE, CIGNA HMO & PPO, TRICARE PRIME(NEEDS REFERRAL)
PRIVATE HEALTH CARE SYSTEMS (PHCS) , UNITED HEALTHCARE PPO

We do not accept:

AMERIGROUP, CIGNA HEALTH SPRING, CONVENTRY HEALTHCARE, EVERCARE, MEDSTAR HMO/PPO
GEORGE WASHINGTON UNIV HEALTH PLAN, KAISER, MDIPA/OPTIMUM CHOICE,
MEDICAID-MARYLAND MEDCIAL ASSISTANCE, PRIME HEALTH, PRIORITY PARTNERS, (UNITED HEALTHCARE STATE OF MARYLAND)

If your insurance is not in any of the list above and you have a question whether our office accepts your insurance, please do not hesitate to call us.

***** Narcotic medication is not refilled unless you come in for an appointment. *****

ATTENTION: Narcotic and Opioid Prescriptions WILL NOT be dispensed to any New patients on their first visit---If you currently take any of these medications please continue getting your refills from your current physician. Thank you for making these arrangements before you arrive.

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Arthritis & Pain Associates of P.G. County

RHEUMATOLOGY

9131 Piscataway Rd.
Suite 310
Clinton, Maryland 20735
(301) 345-5600
TAX ID NO. 52-1939631

					DATE
PATIENT NAME FIRST	MIDDLE	LAST			DATE OF BIRTH
HOME ADDRESS APT. NO		CITY	STATE		ZIP CODE
OCCUPATION EMPLOYED [ ] FT. [ ] PT. RETIRED [ ] STUDENT [ ]	SOCIAL SECURITY NUMBER	MARITAL STATUS [ ]S [ ]M [ ]D [ ]W	SEX		HOME PHONE
EMPLOYER (OR PREVIOUS EMPLOYER, IF RETIRED)		ADDRESS			WORK PHONE
E-MAIL ADDRESS		BEST NUMBER TO CONTACT YOU [ ] HOME [ ] CELL [ ] WORK			CELL PHONE
SPOUSE NAME		SPOUSE PHONE NUMBER [ ] HOME [ ] CELL [ ] WORK			
EMERGENCY CONTACT	RELATIONSHIP	HOME/ CELL PHONE			WORK PHONE
PRIMARY/REFERRING PHYSICIAN		ANY DRUG ALLERGIES/ IF SO, LIST			

WHO CAN WE THANK FOR REFERRING YOU:_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME		ID OR POLICY NUMBER		GROUP/CODE
INSURANCE COMPANY ADDRESS		SUBSCRIBER'S SOCIAL SECURITY		DATE EFFECTIVE
SUBSCRIBER'S NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT	
SUBSCRIBER'S ADDRESS IS THIS THROUGH EMPLOYER [ ]		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH	
SECONDARY INSURANCE COMPANY NAME OR INDIVIDUAL [ ]		ID OR POLICY NUMBER		GROUP/CODE
INSURANCE COMPANY ADDRESS		SUBSCRIBER'S SOCIAL SECURITY		DATE EFFECTIVE
SUBSCRIBER'S NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT	
SUBSCRIBER'S ADDRESS		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH	

X_____
sign

PATIENT AUTHORIZATION

I, hereby authorize Arthritis & Pain Associates of P.G. County to apply for benefits on my behalf for covered services rendered to me by Arthritis & Pain Associates of P.G. County I request payment from Medicare and/or my other health insurance be made directly to the above named Medical Practice or Physicians. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize copy of the authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

_____ X_____

Date Signature of Subscriber or Beneficiary

Local Pharmacy:	ACCOUNT NUMBER
Mail Away Pharmacy:	
Specialty Pharmacy:	

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Family and Friends Contact Form

Persons who are involved in you care (family, friends, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note in emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specially listed on this form).

Please list those persons (including Family & Friends) with who we may share you information:

_____ _____

_____ _____

_____ _____

_____ _____

From time to time we will leave a message for you (as stated in our Notice of Privacy Practices) on an answering machine, voice mail, or with another individual in your absence. **Is it OK for such a message to include <u>details</u> (such as diagnosis, Lab results, Radiology results, medication information, appointment changes) at this number?**

Phone number you can leave a message on: (___) _____ Circle: Home Work Cell

Or (___) _____ Circle: Home Work Cell

_____ _____
Signature or Patient or Legal Representative **Date**

_____
Date of Birth

_____ _____
Print Name of Patient or Legal Representative **Relationship to Patient**

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Consent for Use and Disclosure of Protect Health Information

We use information that you provide to us, including health information, to carry out treatment, payment and health care operations. Please refer to our "Notice of Privacy Practices" for a more complete description. You have the right to review the notice before signing this consent.

The terms of our Notice of Privacy Practices may change. You may obtain a revised notice from our receptionists or by calling our office administrator at (301)-345-5600.

You have the right to request that we restrict the use of your health information to carry out treatment, payment or healthcare operations. We are not required to agree to the restriction. If we do agree to any restriction, the agreement is binding on use.

I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment and health care operations purposes.

Patient Name: (Print) _____

(Signature)_____

Date: _____

Patient acknowledges receipts of Notice of Privacy Practices _____ (Initials & Date)

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Patient Name: _____

Please provide us with the name and address of your primary care physician so we will be able to send him/her our findings.

If you would like us to send our findings to any other doctor you see, please include their name and address as well.

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician's Name & Address & Phone Numbers

_____

_____

_____

Phone: _____ Fax: _____

Send results to this physician as well

Physician's Name & Address & Phone Numbers

_____

_____

_____

Phone: _____ Fax: _____

****Please provide the following information for ALL other doctor's you have seen in the past year****

Patient Name: _____

Doctor's Name & Address & Phone Numbers

_____

_____

_____

Phone: _____ Fax: _____

Doctor's Name & Address & Phone Numbers

_____

_____

_____

Phone: _____ Fax: _____

Doctor's Name & Address & Phone Numbers

_____

_____

_____

Phone: _____ Fax: _____

HISTORY FORM

Information is important to your health; much is required for government and insurance. Answer every questions.

NAME: _____ DATE OF APPOINMENT: _____

WHO REFERRED YOU? _____

WHO IS YOUR PRIMARY CARE DOCTOR? _____

WHO ARE YOUROTHER DOCTORS AND THEIR SPECIALITIES?

_____

_____

PAST MEDICAL HISTORY: *(hepatitis, ulcers, psoriasis, high blood pressure, diabetes, heart disease, etc.)*

1. _____ 3. _____
2. _____ 4. _____

ALLERGIES: DRUGS: _____ **OTHER:** _____

FAMILY MEDICAL HISTORY: *(What illness in family – arthritis, gout, lupus, thyroid, psoriasis, high blood pressure, colitis, inflammatory bowel disease fibromyalgia, ect,.)*

_____

_____

SOCIAL:

Exercise: ____ Inactive ____ Light ____ Moderate ____ Heavy ____ Vigorous

Nutrition: ____ Well balanced diet ____ Poor balanced diet

Sleep: ____ daytime drowsiness ____ Difficult falling asleep ____ Difficult remaining asleep

I get ____ hours of sleep/night on average.

Alcohol Use: ____ Nondrinker ____Drink≥ 4 drinks/day ____2-3 drinks/day ____≤, drinks/day

Caffeine Use: ____ Yes (type _____ servings a day ____) ____ No I don't consume caffeine

Recreational Drug Use: ____In the past but quit (Types: _____) ____ Current User ____ Never Used

Tobacco: ____ Never smoked ____ Used to smoke (stopped ____ months/yrs. ago) ___Use Now Type? ____

MEDICATIONS (include vitamins and supplements):

NAME	DOSE	FREQUENCY
1.		
2.		
3.		
4.		
5		
6.		
7.		
8.		
9		
10.		

PREGNANCY: ___How many times? __ How many live births? __ How many miscarriages __ How many abortions

PREVIOUS SURGERIES: *(tonsillectomy, hysterectomy, etc.)*

1. _____Year_____ 3. _____Year_____
2. _____Year_____ 4. _____Year_____

HEALTH MAINTENANCE: Have you had a Pneumovax (pneumonia vaccine)? ___ When? _____

Have you had the Flu Shot? ____ When? _____

Have you had a bone density x-ray (DXA scan)done? ____ When? ____ Where? _____

Have you had a TB skin test? ____ Result = ____ Where? _____ When? _____

HOSPITALIZATIONS, *Medical: (pneumonia, infections, etc.)*

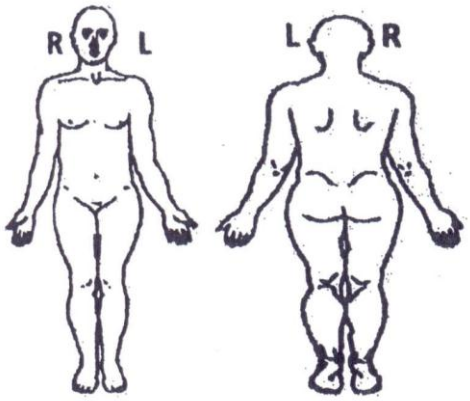
1. _____Year_____ 3. _____Year_____
2. _____Year_____ 4. _____Year_____

NAME: _____ DATE OF APPOINMENT: _____

What is you main reason for visit today? _____

Symptoms: If you joints are stiff in the morning, how long does it take to loosen up in average? _____

Pain Location on diagrams below: Circle areas of recent pain on diagram if you have pain.



Pain Quality: Circle one (sharp, dull, aching, burning, stinging, throbbing)

Current Duration: How long has this episode been occurring? (___ minutes, ___ hours, ___ days, ___ weeks)

Progression: Circle one: My conditions is (worsening, unchanged, improving)

REVIEW OF SYMPTOMS

(As you review the following list, please check any problems which have **SIGNIFICANTLY** affected you **RECENTLY)**

[ ]	APPETITE LOSS	[ ]	ABDOMINAL MASS
[ ]	EXCESSIVE CRYING	[ ]	ABDOMINAL PAIN
[ ]	FEVER	[ ]	BLACK, TARRY STOOL
[ ]	HAIR LOSS	[ ]	BACK PAIN
[ ]	DRY SKIN	[ ]	JOINT REDNESS
[ ]	RASH	[ ]	JOINT SWELLING
[ ]	HEADACHE	[ ]	DECREASED MEMORY
[ ]	DRY EYES	[ ]	FINGERS TURN COLOR WITH COLD
[ ]	RED EYE (CONJUNCTIVITIS)	[ ]	NUMBNESS
[ ]	NECK PAIN	[ ]	ANXIETY, EXCESSIVE WORRIES
[ ]	NECK STIFFNESS	[ ]	DEPRESSION
[ ]	SWOLLEN GLANDS	[ ]	DIFFICULTY SLEEPING
[ ]	BLOODY SPUTUM	[ ]	APPETITE CHANGES
[ ]	CHRONIC COUGH	[ ]	COLD INTOLERANCE
[ ]	DIFFICULTY BREATHING	[ ]	HEAT INTOLERANCE
[ ]	ABNORMAL BLOOD PRESSURE	[ ]	ABNORMAL BLEEDING
[ ]	CLAUDICATION... walking calf cramps	[ ]	ANEMIA
[ ]	EDEMA (Swollen Ankles)	[ ]	BLOOD CLOTS

I attest that the above information is true and correct to the best of my belief.

SIGNATURE: _____ DATE: _____

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