ARTHRITIS & RHEUMATOLOGY ASSOCIATES
Of Palm Beach

MICHAEL SCHWEITZ, M.D. • JONATHAN GREER, M.D. • AMIEL TOKAYER, M.D. • RUI CEREJO, D.O.
MARICARMEN QUINTERO, M.D. • PAUL MENDOZA, M.D. • CATHERINE GARCIA, M.D. • RACHEL TATE, D.O.
AARON COHEN, PA-C • BRUNA PURGATO DANTAS, PA-C

Specializing In Arthritis & Rheumatic Diseases

DATE:_____

LAST NAME	FIRST NAME	MI

DATE OF BIRTH	AGE	GENDER	MARITAL STATUS	OCCUPATION:
		☐ M ☐ F	☐ S ☐ M ☐ D ☐ W	

BIRTHPLACE	RACE	ETHNICITY: HISPANIC OR LATINO	IF YES, ORIGIN
		☐ YES ☐ NO	

HOME PHONE	WORK PHONE	MOBILE PHONE	NORTHERN PHONE NUMBER, IF APPLICABLE

EMAIL ADDRESS:	

STREET ADDRESS	CITY	STATE	ZIP CODE

NORTHERN STREET ADDRESS, IF APPLICABLE	CITY	STATE	ZIP CODE

PARENT'S NAME (IF MINOR)	PARENT'S PHONE NUMBER	EMERGENCY CONTACT	RELATIONSHIP	EMERGENCY CONTACT#

PRIMARY CARE DOCTOR	

REFERRED BY	☐ SELF ☐ FAMILY ☐ FRIEND ☐ DOCTOR ☐ OTHER HEALTH PROFESSIONAL NAME OF PERSON MAKING REFERRAL:

I WOULD LIKE TO SCHEDULE WITH:

☐ DR. MICHAEL SCHWEITZ ☐ DR. JONATHAN GREER ☐ DR. AMIEL TOKAYER
☐ DR. RUI CEREJO ☐ DR. MARICARMEN QUINTERO ☐ DR. PAUL MENDOZA
☐ DR. CATHERINE GARCIA ☐ DR. RACHEL TATE

OR, ANY RHEUMATOLOGIST WITH THE SOONEST AVAILABLE APPOINTMENT AT THE FOLLOWING LOCATION: ☐ BOYNTON BEACH ☐ PALM BEACH GARDENS ☐ WEST PALM BEACH ☐ ANY LOCATION

PATIENT PORTAL CONSENT:

INITIAL _____ I GIVE AUTHORIZATION TO REGISTER FOR A PATIENT PORTAL ONLINE ACCOUNT USING MY EMAIL ADDRESS GIVEN ABOVE. I UNDERSTAND THAT THE PORTAL SHOULD NOT BE USED FOR EMERGENCIES AND ACKNOWLEDGE THAT I WILL NOT RECEIVE IMMEDIATE RESPONSES TO QUESTIONS, MEDICAL REQUESTS, MEDICATION REQUESTS, OR APPOINTMENT REQUESTS. I UNDERSTAND THAT ARTHRITIS AND RHEUMATOLOGY ASSOCIATES OF PALM BEACH IS NOT RESPONSIBLE FOR ILLNESS OR INJURY FROM MY CHOICE TO NOT SEEK EMERGENCY TREATMENT.

Arthritis & Rheumatology Associates of Palm Beach

Name _____ Date: _____/_____/_____
FIRST MIDDLE INITIAL LAST MONTH DAY YEAR

Birthdate _____/_____/_____
MONTH DAY YEAR

Do you have an orthopedic surgeon? _____ Yes _____ No. If yes, name: _____

What is the main reason for today's visit?:

_____

_____

_____

Date symptoms began (approximate) _____

Diagnosis given? (Please list)

_____

_____

_____

_____

Please list the name of other practitioners you have seen for this problem:

_____

_____

_____

Previous treatment for this problem (include physical therapy, surgery and injections: medication to be listed later)

_____

_____

_____

Do you drink alcoholic beverages? _____ Yes _____ No If yes, how many drinks per week? _____
Do you smoke? _____ Yes _____ No _____ Former smoker If yes/former smoker, how many packs per day? ___

ALLERGIES TO MEDS? ☐ YES ☐ NO LATEX ALLERGY? ☐ YES ☐ NO

IF YES, LIST MEDICATIONS WITH TYPE OF REACTION:

MEDICATION	**REACTION**

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MEDICATIONS

PLEASE ATTACH A PRE-PRINTED MEDICATION LIST

OR,

LIST **ALL** CURRENT PRESCRIPTIONS/VITAMINS/OVER-THE-COUNTER MEDS:

Name of Drug	Dose (Include strength and number of pills per day)	How long have you taken this medication?

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had or been diagnose with any of the following? (check if "yes")

	Yourself	Relative (name/relationship)
Arthritis (type unknown)	☐	☐ _____
Childhood arthritis	☐	☐ _____
Rheumatoid Arthritis	☐	☐ _____
Rheumatic Fever	☐	☐ _____
Gout	☐	☐ _____
Psoriatic Arthritis	☐	☐ _____
Lupus or "SLE"	☐	☐ _____
Ankylosing spondylitis	☐	☐ _____
Osteoarthritis	☐	☐ _____
Osteoporosis	☐	☐ _____

ARTHRITIS & RHEUMATOLOGY ASSOCIATES OF PALM BEACH

PAST MEDICAL HISTORY

- ☐ GERD / Stomach Ulcers
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostate Hypertrophy
- ☐ Blood Clots
- ☐ Cancer
  - Type(s): _____
  - _____
  - Chemotherapy? YES NO
  - Radiation? YES NO
- ☐ Stroke Year:_____
- ☐ COPD
- ☐ Coronary artery Disease
- ☐ Myocardial Infarction "Heart Attack" Year: _____
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Hyperthyroidism (Graves)
- ☐ Hypothyroidism
- ☐ Irritable Bowel
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Hepatic/liver disease
- ☐ Migraine headaches
- ☐ Psoriasis
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Ulcerative Colitis
- ☐ Other (please list)
  - _____
  - _____
  - _____
  - _____

PAST SURGICAL HISTORY

- ☐ Angioplasty (stents or balloon)
- ☐ Appendectomy
- ☐ Arthroscopy
  - ☐ Knee
    - ☐ Right ☐ Left Year: _____
  - ☐ Shoulder
    - ☐ Right ☐ Left Year: _____
- ☐ Back
- ☐ Breast
  - ☐ Lumpectomy/Mastectomy
    - ☐ Right ☐ Left
  - ☐ Implants
  - ☐ Other cosmetic
- ☐ Cardiac Bypass (CABG)
- ☐ Cardiac Pacemaker
- ☐ Carpal Tunnel
  - ☐ Right ☐ Left
- ☐ Cataracts
- ☐ Cholecystectomy (gall bladder)
- ☐ Colectomy/Bowel resection
- ☐ Gastric Bypass Year: _____
- ☐ Hernia Repair
  - ☐ Right ☐ Left Year: _____
- ☐ Hip Replacement
  - ☐ Right ☐ Left Year: _____
- ☐ Knee Replacement
  - ☐ Right ☐ Left Year: _____
- ☐ Bone Fracture Repair (please describe):
  - _____
- ☐ Shoulder Replacement
  - ☐ Right ☐ Left Year: _____
- ☐ Thyroid
- ☐ Other (please list)
  - _____ Year: _____
  - _____ Year: _____
  - _____ Year: _____
  - _____ Year: _____
  - _____ Year: _____

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FAMILY HISTORY:

	If living		If deceased	
	Age	Health	Age of death	Cause
Father				
Mother				
Sibling				
Sibling				
Sibling				

REVIEW OF SYSTEM

Please check if you currently have any of the following:

- ☐ Skin Problems
- ☐ Rashes
- ☐ Hives
- ☐ Eczema
- ☐ Bleeding Problems
- ☐ Nail Changes
- ☐ Balding/Hair loss
- ☐ Sun sensitivity
- ☐ Easy Bruising
- ☐ Masses or Lumps

  Where? _____
- ☐ Jaundice
- ☐ Fainting Spells
- ☐ Fatigue
- ☐ Swelling of Legs
- ☐ Night Sweats
- ☐ Insomnia
- ☐ Depression
- ☐ Nervousness
- ☐ Fevers
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Mouth Sores
- ☐ Throat Problems
- ☐ Shortness of Breath
- ☐ Frequent Cough
- ☐ Cough Up Blood
- ☐ Blood in Phlegm
- ☐ Frequent Colds
- ☐ Sinus Infections
- ☐ Impaired Hearing
- ☐ Freq Ear Infections
- ☐ Ear Swelling
- ☐ Weak Muscles
- ☐ Muscle Pain
- ☐ Chills
- ☐ Indigestion
- ☐ Poor Appetite
- ☐ Abdominal Cramps
- ☐ Rectal Bleeding
- ☐ Visual Problems
- ☐ Blindness
- ☐ Dry Eyes
- ☐ Frequent Headaches
- ☐ Dizziness
- ☐ Vertigo
- ☐ Memory Problems
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Genital Sores
- ☐ Menstrual Problems
- ☐ Last Menstrual Period _____
- ☐ Freq. Kidney Infection
- ☐ Freq. Bladder infection
- ☐ Heart Palpitations
- ☐ Unintentional Weight Loss
- ☐ Recent Weight Gain
- ☐ Tingling
- ☐ Numbness
- ☐ Chest Pain

ARTHRITIS & RHEUMATOLOGY ASSOCIATES OF PALM BEACH

To our patients,

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to an address other than your home address.

The physicians and staff of the Arthritis & Rheumatology Associates of Palm Beach respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind, please indicate your preferences for the areas noted below.

I wish to be contacted in the following manner (check ALL that apply):

- ☐ Home/Cell Telephone _____
  - ☐ Leave message with ***detailed*** information
  - ☐ Leave message **ONLY** with call back number
- ☐ Work Telephone _____
  - ☐ Leave message with ***detailed*** information
  - ☐ Leave message **ONLY** with call back number
- ☐ Written Communications
  - ☐ Mail to my home address
  - ☐ Mail to my work/office address
  - ☐ Fax to this number:_____

You may speak with the following individuals (spouse, family, caretakers, etc.) regarding:

- ☐ My care or treatment (blood results, etc.)
- ☐ My bills
- ☐ My appointments
- ☐ Prescriptions (**giving permission to pick up medicine scripts as well*)

Name	*Relationship*
_____	_____
_____	_____
_____	_____

I understand that I may revoke this authorization at any time with written notification to Arthritis & Rheumatology Associates of Palm Beach.

_____	_____
Print Patient Name	*Date of birth*
_____	_____
Patient Signature	*Date*

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Patient Name:_____ Date of Birth: _____

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices (a hard copy given in office and a digital format is available online), which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we must try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

I have received the Notice of Privacy Practices (effective date August 19, 2019)

_____ _____
Patient's (or Legal Representative's Signature) Date

_____
Relationship of Legal Representative

For office use only

To be completed only if Acknowledgment is not signed.

1) Was the patient given a copy of the Notice of Privacy Practices?
[ ] Yes [ ] No

2) Please explain why the patient was unable to sign this Acknowledgment and our efforts to try to obtain the patient's signature:

_____
_____
_____
_____
_____

_____ _____
Name/Title Date

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NO SHOW POLICY

In an effort to address this concern and continue to meet the needs of our patients, we have developed the following No Show Policy.

1. To cancel an appointment, we require advance notice of 48 hours.
2. For appointments canceled in 24 hours or less, or for missing an appointment, a fee of $25 will be levied to cover administrative expenses.
3. Patients who do not schedule within 30 days or have a history of repeatedly not showing may be subject to dismissal for "non-compliance."

_____ _____

Patient Signature Date

INSURANCE HOLDER, CO-PAY & REFERRAL POLICY

It is the patient's responsibility to be aware of their insurance co-pay amount and referral requirements. All co-payments are to be made at the time of visit. The patient is responsible to bring or confirm with the office that a referral is on file prior to scheduled appointment, if it is required. Failure to cooperate may result in the appointment being rescheduled.

_____ _____

Patient Signature *Date*

Insurance Holder: ☐ Self (Patient) ☐ Other (Please fill out the following)

Name of Insurance Holder:_____

Relationship to Patient:_____

Date of Birth:_____

Social Security Number:_____

Insurance Company: _____

Policy #: _____

RETURN CHECK POLICY

If a patient's check is returned by the bank, the patient will be charged a fee of $25.00 and will no longer be allowed to make payments with checks.

_____ _____

Patient Signature *Date*

PHARMACY INFORMATION

Name of your pharmacy: _____

Pharmacy phone #: _____

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