

Dear Prospective Patient:

On behalf of our staff and ourselves, we would like to welcome you to our practice. We look forward to meeting you and addressing your rheumatologic concerns.

Enclosed you will find a patient information form and a detailed medical history outline to be completed and brought with you for your appointment. If you prefer, this form may be mailed or brought in to the office prior to the appointment. Completion of the form will greatly assist in our evaluation. The medical history form allows us to assess the "whole person" when evaluating your rheumatologic history.

If, for any reason, you must cancel or reschedule your appointment, please notify us no later than 24 hours in advance of your appointment time.

Please remember to bring:

- a copy of your medication list (vitamins, herbs and minerals)
- recent laboratory tests
- recent pertinent x-rays
- medical records (make arrangements for your primary doctor to send them to us)

We are committed to offering you an accurate diagnosis and a thorough discussion of treatment options. We are eager to help relieve pain, preserve musculoskeletal function and monitor treatment to prevent adverse reactions. Your active role in these efforts is vital to our success.

Please do not hesitate to contact our office if you have any questions or concerns. Our entire staff looks forward to your initial visit with us.

Sincerely,



Frank J. Nolan, M.D., A.P.C.



Paul H. Brion, M.D.

Acknowledgement of Receipt of Notice of Privacy Practices

ARTHRITIS CONSULTANTS OF NORTH COUNTY

Privacy Officer 760-724-5800

I hereby acknowledge that I have been offered a copy of this office's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient

Name of Patient: _____

Patient Information

Date: _____ Birthdate: _____
Patient Name: _____ M F
Address: _____
City: _____ State: _____ Zip: _____
Home Telephone Number: _____ Work: _____
Cell Number _____ E-Mail Address _____
Social Security Number: _____ Driver's License# _____
Primary Care Doctor: _____
Occupation: _____ Retired Yes or No
Spouse or Partner: _____ Birthdate: _____
Medical Insurance: (Primary): _____
(Secondary): _____
Responsible Party: _____
Please present insurance cards at time of visit
Emergency Contact: _____

Assignment and Release

I, the undersigned, assign all medical benefits to the Physicians at Arthritis Consultants of North County. I also authorize release of any medical information to process my insurance claim. I also will allow progress reports, lab and x-ray results, to be shared with my other physicians, unless otherwise specified.

Signature: _____

Please notify this office if there are any changes to the above



Patient History Form

Name: _____
Last First M

Birthdate: ____/____/____
Month Day Yr

Date of Appointment: ____/____/____
Month Day Year

Age: _____

Sex: ___F ___M

Name of physician/person who referred you: _____

Name of your primary physician (if different): _____

List your other physicians: _____

Briefly describe the reason for your referral: _____

Date symptoms began: _____ Diagnosis given: _____

Previous treatments given for this problem: _____

Arthritis History

Have you ever had any of the following: (please check)

- | | |
|---|---|
| <input type="checkbox"/> Arthritis (type unknown) | <input type="checkbox"/> Lupus "SLE" |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Ankylosing spondylitis |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Gout | |

Other arthritis conditions: _____

Past Personal History:

Do **you** have, or have **you** ever had: (please check)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Bad Headaches | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Colitis | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Cancer (list type) |

Other significant illnesses (Please list): _____

Previous Operations:

Type	Year

Any previous fractures?: No Yes Describe _____
 Any other serious injuries? No Yes Describe _____

Family History:

	If living		If deceased	
	Age	Health	Cause	Age at death
Father				
Mother				

Number of siblings: _____ Number of children: _____

Do you have a blood relative with: (please check)

- | | | | |
|-----------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Goiter | |

Social History:

Never Married Married Divorced Separated Widowed
 Spouse: Alive/Age _____ Deceased/Age _____

Your occupation (current or previous): _____

Do you smoke? Yes No Never If yes, # Cigarettes per day? _____
 Do you drink alcohol? Yes No If yes, I drink _____ drinks per _____
 # day / week / month

Allergies

Are you allergic to medicines? Yes No

If yes, list medications and reaction: _____

