LONG ISLAND REGIONAL
ARTHRITIS & OSTEOPOROSIS
CARE

Thank you for scheduling an appointment at our office on_____

We are delighted that you have chosen our practice for your care and we look forward to your visit.

Please complete all pages in this packet and bring in with you to your appointment. In addition, please bring a list of any medications or supplements you are taking, your insurance cards, driver's license, and co-pay. We ask that you contact your Primary Care Physician or referring physician to have pertinent medical records faxed to us at 631-376-4800.
Should your insurance require referrals, it is your responsibility to obtain the referral prior to your appointment.
We may not be able to see you if a referral is not on file with our office by the scheduled appointment date.
We make every effort to contact you a day prior to your appointment to confirm. When you get a message to call and confirm, please give us the courtesy of a response in return. Due to the nature of this practice, we ask new patients arrive 10 minutes prior to your scheduled time so we can process all your paperwork and insurance information into our system. It is the policy of the practice to assess a charge for patients who do not keep their scheduled appointment or cancel with less the 24-hour notice.

Co-pays are payable at the time of service. We accept all major credit cards, checks and/or cash.

For more information about our practice, please visit us on the web at www.bonesandjointcare.com

We look forward to serving your Rheumatological needs. Should you have any questions, please contact our office at 631-376-2663.

Sincerely,

Long Island Regional Arthritis and Osteoporosis Care, PC
500 West Main Street, Suite 110
Babylon, New York 11702
631-376-BONE (2663)

Patient Information Sheet

Last Name: _____ **First** _____ **MI:**____ **Date:** _____

Mailing Address_____ Date of Birth_____ M_____ F_____

City_____ State_____ Zip_____

Home phone: ( ) _____ Cell phone: ( ) _____ Work phone: ( ) _____

Primary Care Physician _____ Social Security #_____

Email address: _____

Emergency Contact:

Name_____ Relationship_____

Address_____ City/State_____ Phone ( ) _____

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes If Yes how long? _____

Past smoker, how long ago _____

_____

Do you drink alcohol? ☐ No ☐ Yes amount per week_____

Do you use drugs for reasons that are not medical?

☐ No ☐ Yes, If yes please list: _____

_____

Do you exercise regularly? ☐ Yes ☐ No

Type_____

Amount per week_____

How many hours of sleep do you get at night? _____

Do you wake up feeling rested? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you now or have you ever had: (check the box)

☐ Cancer If so what type?

☐ Goiter ☐ Hypothyroidism ☐ Stroke ☐ Epilepsy

☐ Diabetes ☐ Heart Problems ☐ Asthma ☐ Cataracts

☐ Nervous Breakdown ☐ Stomach Ulcers ☐ Colitis

☐ Migraines ☐ Jaundice ☐ Rheumatic Fever ☐ IBS

☐ Kidney Disease ☐ Pneumonia ☐ Psoriasis ☐ GERD

☐ Anemia ☐ HIV/AIDS ☐ High Blood Pressure

☐ Emphysema ☐ Glaucoma ☐ Tuberculosis

☐ High Cholesterol ☐ Crohn's Disease ☐ Hyperthyroidism

Are you are snow bird (Do you leave NY for the winter months) ☐ yes ☐ no

Occupation: retired ☐ Yes ☐ No, if still working what is you're **(Job Title)** _____

Any previous Fractures (broken bones)? Please List _____

Any previous Fractures (broken bones)? Please List _____

_____

Have you ever had a Bone Density? _____ Where and when_____

Have you ever had a Workman's Comp or No Fault Case? _____ If so When _____

Why? _____

Drug Allergies: ☐ No ☐ Yes If so to what? _____

_____

Type of reaction: _____

_____

Previous Operations:

Type_____ Year _____ Reason _____

1._____ _____ _____

2._____ _____ _____

3._____ _____ _____

4._____ _____ _____

5._____ _____ _____

6._____ _____ _____

Present	Age	Health	Age of Death	Cause
Father				
Mother				

Siblings Number living_____ Number deceased_____

Children Number living_____ Number deceased_____

Present Medications (list any medications you are taking. Including such items as aspirin, vitamins, laxatives, calcium etc.)

NAME OF DRUG	Dosage	how many times a day
1.		
2.		
3.		
4.		
5.		
6.		
7		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

Signature_____ Date_____

REVIEW OF SYSTEMS

Constitutional		
Weight gain (>5 lbs)	O Yes	O No
Weight loss(>5 lbs)	O Yes	O No
Loss of appetite	O Yes	O No
Recurring fever	O Yes	O No
Fatigue	O Yes	O No
Eyes, Ears, Nose & Throat		
Diminished vision	O Yes	O No
Blurring of vision	O Yes	O No
Dry eyes	O Yes	O No
Red eyes	O Yes	O No
Sores in mouth	O Yes	O No
Scalp tenderness	O Yes	O No
Dry mouth	O Yes	O No
Jaw Pain w/ chewing	O Yes	O No
Ringing in ears	O Yes	O No
Respiratory		
Shortness of breath	O Yes	O No
Cough	O Yes	O No
Wheezing(asthma)	O Yes	O No
Coughing blood	O Yes	O No
Cardiology		
Dizziness	O Yes	O No
Chest pain	O Yes	O No
Palpitations	O Yes	O No
Gastrointestinal		
Blood in stool	O Yes	O No
Diarrhea	O Yes	O No
Constipation	O Yes	O No
Nausea/ Vomiting	O Yes	O No
Difficulty swallowing	O Yes	O No
Abdominal pain	O Yes	O No
Black stools	O Yes	O No
Heartburn	O Yes	O No
Endo/ GYN/ GU		
Vaginal dryness	O Yes	O No
Freq. night urination	O Yes	O No
Prior kidney stones	O Yes	O No
Irregular periods	O Yes	O No
Previous pregnancies	O Yes	O No
Miscarriages (>2)	O Yes	O No
Psychiatric		
Depression	O Yes	O No
Sleep disturbance	O Yes	O No
Eating disorder	O Yes	O No
Anxiety	O Yes	O No
Musculoskeletal		
Joint stiffness	O Yes	O No
Joint pain	O Yes	O No
Joint swelling	O Yes	O No
Joint redness	O Yes	O No
Prior bone fractures	O Yes	O No
Skin		
Rash	O Yes	O No
Hives	O Yes	O No
Raynaud's	O Yes	O No
Alopecia/ hair loss	O Yes	O No
Sun Sensitivity	O Yes	O No
Nodules/ bumps	O Yes	O No
Skin tightness	O Yes	O No
Swollen lymph nodes	O Yes	O No
Neurology		
Headaches	O Yes	O No
Tingling Numbness	O Yes	O No
Seizures	O Yes	O No
Memory loss	O Yes	O No
Dizziness	O Yes	O No
Weakness	O Yes	O No
Restless leg symptoms	O Yes	O No
Difficulty walking	O Yes	O No
Sensitivity hands/feet	O Yes	O No
Muscle spasm	O Yes	O No

Name:_____ Date:_____

Signature_____

Long Island Regional

Arthritis & Osteoporosis Care, PC

Receipt of Notice of Privacy Practices

Written Acknowledgement form

I, _____, have received/been offered a copy of the Notice of Privacy Practices from the Long Island Regional Arthritis & Osteoporosis Care, PC.

Signature of Patient_____

Date_____

The following person(s) may be contacted by Long Island Regional Arthritis & Osteoporosis Care, PC staff regarding my care, or insurance matters.

Name	Relationship
1. _____	_____
2._____	_____
3. _____	_____
4. _____	_____
5._____	_____

Narcotic Medication Policy

Please note that Long Island Regional Arthritis & Osteoporosis Care, PC is a consultation and treatment center. We are here to diagnose and treat Rheumatologic conditions. We are not a pain Management Center. Our Providers will only dispense narcotic medications temporarily to patients with acute conditions. If you require narcotic medications on a continuous basis, we suggest you seek the services of Pain Management.

_____ _____

Signature Date

Consent to Obtain External Prescription History

I, _____ whose signature appears below,

Authorize Long Island Regional Arthritis & Osteoporosis Care, PC

To view my external prescription history.

I understand that prescription history comes from multiple other sources

And providers and staff.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE

OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ _____

Signature Date

Long Island Regional

Arthritis & Osteoporosis Care, PC

Patient Name: _____

Date: _____

CANCELLATION/ MISSED APPOINTMENT POLICY

Your appointment has been set aside for you. This time is unavailable to other patients. Therefore, we require at least 24 hour advance notice if you need to cancel your appointment. For all missed or cancelled appointments with less than 24 hour notice you will be charged a $40.00 cancellation fee. Appointment reminder calls are a courtesy. Should you not receive a reminder telephone call, it is still your responsibility to remember your appointment.

I have read and understand the cancellation/missed appointment policy _____
(Patient Signature)

If Patient is a minor, please provide parent or guardian's information

Name_____ Relationship_____

Parent or Guardian _____

Patient Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please ask to discuss them with the practice manager. We are dedicated to providing the best possible care and service to you. We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Your insurance policy is a contract between you and your insurance company only. If you fail to notify us of an insurance change, you are fully responsible for ant amount not paid by your insurance company.

If you have insurance coverage with a plan we do not have a prior agreement with, we will prepare and submit the claim for you. However, our changes for your care and treatment are due to us from you at the time of the service.

Unless either you or your health coverage carrier have made other arrangements in advance, payment is due at the time of service. For your convenience we will accept VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER CARD or a personal check with a valid license. If you have a financial hardship, an arrangement for financial plan may be possible.

All Health plans are not the same and do not cover the same services. In the event your plan determines a service not to be covered you will be responsible for the complete charge.

For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred.

Ant patient balances are due within 30 days of receipt of statement. There will be a $25 late fee charge on any outstanding balance unless previous arrangements have been made with the billing office.

Guarantee of payment form

Many insurance companies, including manage care organizations, require prior written authorization for treatments. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received a prior approval for the services or authorization has been denied, you are fully responsible for all charges your insurance company does not agree to pay. In addition you will be responsible for all deductibles, co-insurances, co-payments and services that are not covered by your insurance plan and any services that your insurance company has determined not to be medically necessary.

I have read and understand the information above. I understand that my insurance company may deny coverage and request that Long Island Regional Arthritis and Osteoporosis Care, PC perform this medical service anyway. I agree to personally and fully be responsible for all charges. I understand that Long Island Regional Arthritis and Osteoporosis Care, PC is relying and this promise and is rendering services without requiring payment at the time of the service based on such reliance.

_____ _____ _____

(Print name) (Signature) (Date)

Healthcare Surrogate Form

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate the following individual as my surrogate for health care decisions:

☐ Non-Surrogate
(You make your own decisions)

☐ Surrogate Needed
(Person makes decisions on your behalf)

Surrogate Information

First Name _____ Last Name _____

Mailing address _____

City, State, Zip Code _____

Phone _____ Email Address _____

Your Name _____ Date _____

Signature _____