ARTHRITIS SPECIALISTS, LTD.

Patient Registration

FULL NAME: MARY LORRAINE CREWS					S.S. NUMBER: 578-64-1781
ADDRESS: 8206 AMARA PL				CHESTERFIELD	STATE AND Z: VA 23838
BIRTH DATE: 11/07/1947	AGE: 76	FEMALE	MARRIED	PR: 864-404-8769	SECONDARY PHONE:
LANGUAGE: ENGLISH		RACE: HUMAN		ETHNIC GROUP: AFRICAN AMERICAN	

EMPLOYER: RETIRED	OCCUPATION:
ADDRESS:	BUSINESS PHONE:

EMERGENCY CONTACT: OTIS J CREWS	PHONE: 301-467-8523
ADDRESS (IF DIFFERENT FROM ABOVE):	

FAMILY PHYSICIAN (IF ANY): DR ADAM GONZALEZ	LOCATION: 13710 St. Francis Boulevard MIDLOTHIAN VA 23114	PHONE: 804-423-5050
REFERRING PHYSICIAN (IF ANY): DR. KATHERINE PRICE	LOCATION: 13551 WATERFORD PL MIDLOTHIAN VA 23112	PHONE: 804-320-4243

Insurance Information (Name of Insurance Companies)

PRIMARY	SECONDARY	TERTIARY
MEDICARE	TRI-CARE 4 LIFE	

PATIENT AUTHORIZATION

I hereby authorize the release of medical information to my physician(s) or my insurance company.
In order to help us provide you with the best services possible, we have adopted the following billing policy:

I understand that I am responsible for payment of my bill in full, regardless of what my insurance pays.

In the event that the responsible party defaults on payment to this office for professional services rendered within the preceding 60 days, the responsible party agrees to pay to Arthritis Specialists, Ltd. expenses incurred in effecting collection of this account, including attorney's fees equal to 33 1/3% of the balance due, as well as applicable court costs. These sums are expressly recognized to be in addition to the balance on the account at the time it is placed for collection.

Arthritis Specialists, Ltd. requires at least 24 hours notice for all appointment cancellations. If you are unable to provide 24 hours notice, you will be billed a $25.00 charge for your scheduled appointment time.

I request that the physicians and staff of Arthritis Specialists, Ltd. have any and all access to my electronic medical records for the purpose of providing me medical care.

I give my permission for physicians and staff of Arthritis Specialists, Ltd. to leave voice mails on my home phone or work phone.

By supplying my home phone number, mobile phone number, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s) to notify me of pending appointments.

Patient agrees that the physicians of Arthritis Specialists, Ltd. are specialists in Rheumatology and are not in any way practicing as *Primary Care Physicians or General Internal Medicine Physicians* for the patient. Furthermore, patient represents that he or she has a *Primary Care Physician* who serves him or her for general medical problems, both routine and emergency in nature.

Your signature below attests to your understanding and willingness to comply with the above policy. Thank you for your cooperation.
In the event one of Arthritis Specialists, Ltd.'s employees is exposed to your blood or body fluids, you consent to have your blood drawn to test for blood borne pathogens.

Signature: _____ Date 12/13/23

LIFETIME FORM

Beneficiary Name: MARY LORRAINE CREWS Health Insurance #: 8KJ9-VG5-RQ18

I request that payment under the Medicare Insurance Program be made either to me or on my behalf to Arthritis Specialists, Ltd. for any services furnished by that physician/provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

Beneficiary Signature: _____ Date 12/13/23

Arthritis Specialists, Ltd.

Name MARY LORRAINE CREWS **Date** 12/13/23 **DOB** 11/07/1947

Reason for Visit: LAB TEST SHOWED ELEVATED RHEUMATOID FACTOR

Past Medical History __ *No Known Medical History*

__Anxiety	x Arthritis	__Asthma
x Back Pain	x Cancer	__Chronic Renal Insufficiency
__Clots in Legs	__Clots in Lungs	__Congestive Heart Failure
__COPD	__Crohn's Disease	__Depression
__Diabetes (Type I)	__Diabetes (Type II)	__Fibromyalgia
__Gout	x Glaucoma	__Heart Attack
__Heart Disease	__Heart Disease – Angina	__Hepatitis
x High Cholesterol	x Hypertension	__Intestinal Bleeding
__Kidney Stones	__Lupus	__Migraine Headache
__Osteoarthritis	x Osteopenia	__Osteoporosis
__Peptic Ulcer Disease	__Prostate Trouble	x Reflux Heart Burn
__Rheumatoid Arthritis	__Seizures	__Sjogren's
__Strep Throat (Recent)	__Tension Headache	__Ulcerative Colitis
__Underactive Thyroid	__Urinary Tract Infection	

Other:(not listed above) VENTRICULAR PREMATURE BEATS; MDS; CERVICAL CANCER; HIATAL HERNIA; DIVERTICULOSIS OF COLON; CHRONIC RENAL STAGE III

Surgical History/Operations (Please include date if possible) __ *No Known Surgical History*

COLONOSCOPY JUNE 2023

ROBOTIC SIGMOID COLECTOMY SEPT 2022

PARTIAL THRYRODECTOMY 2018

ROTATOR CUFF REPAIR 2014

HYSTORECTOMY; APPENDECTOMY 1989 AND PRIOR

Current Medications, Dosage and Frequency __ *No Known Medication*

Medication	*Dosage*	*Frequency*
AZITHROMYCIN	250 MG	1/DAY
DICLOFENAC SOD EC	75 MG	2/DAY
ROSUVASTATIN	20 MG	1/DAY
METOPROLOL SUCCINATE ER	25 MG	1/DAY
AMLODIPINE BESYLATE	10 MG	1/DAY
OMEPRAZOLE DR	40 MG	2/DAY
CITIRIZINE	10 MG	1/DAY
MICARDIS HCT	80 MG/ 12.5 MG	1/DAY
FLUTICASONE PROPIONATE NS SPR	50 MCG/16 GR	1/DAY

Vitamins

VITAMIN D3; VITAMIN B COMPLEX WITH C; CO Q10

Allergies to Medications (Please include reaction if possible) __ *No Known Drug Allergies*

SUCRALFATE

Social History

(X) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed

Employment – Occupation RETIRED

Current Smoking Status: __Never Smoked __Smoke Every day __Smoke Some Days

X Former Smoker (Packs per day 1) How long have/did you smoked? 25 YR Age Started 19

Do you drink caffeinated beverages? ( ) No (x) Yes Number per day? _____

Do you drink alcohol? (x) No ( ) Yes Number per week? _____

Have you done any illicit drugs? (x) No ( ) Yes

Family History (Please include relation if possible) __ *No Known Family History*

__Ankylosing Spondylitis ( )	__Arthritis ( )	__Asthma ( )	__Cancer (FATHER; BROTHER)
__Crohn's Disease ( )	__Diabetes ( )	__Epilepsy/Seizure ( )	__Gout ( )
__Heart Disease (MOTHER; BROTHER)	__High Blood Pressure (MOTHER; BROTHER)	__Kidney Disease ( )	__Lupus or SLE ( )
__Mental Illness ( )	__Osteoarthritis ( )	__Osteoporosis ( )	__Psoriasis ( )
__Psoriatic Arthritis ( )	__Rheumatoid Arthritis ( )	__Stroke (MOTHER; BROTHER)	__Tuberculosis ( )
__Ulcerative Colitis ( )	Other:		

Review of Systems (please mark the symptoms that you have on a regular basis)

Constitutional Symptoms

x Recent Weight Gain

Amount (lbs.) _____

__Recent Weight Loss

Amount (lbs.) _____

x Fatigue

__Weakness

__Night Sweats

__Fever

Hours of Sleep Per Night_____

__Chills

HEENT

__Dry Mouth/Dry Eyes

__Blurred Vision

__Loss of Vision

__Mouth Ulcers

__Pain or Redness of the Eyes

x Tender Scalp

__Jaw Pain while Chewing Food

Pulmonary

x Coughing

__Wheezing

__Sputum Production

__Shortness of Breath

__Chest Pain with Deep Breath

__Coughing Up Blood

Musculoskeletal

__Morning Stiffness

How long_____

__Joint Pain

__ Joint Swelling

x Neck Pain

x Back Pain

__ Muscle Pain or Tenderness

__Muscle Nodules

__Deformities of the Joints

Other_____

Hematologic/Lymphatic

__Swollen Glands

__Clots in Lungs or Legs

__Anemia

__Excess Bleeding

Skin

__Rash

__Psoriasis

__Tightening of the Skin

__Nodules

__Sensitivity to Sunlight

x Easy Bruising

__Nail Changes or Pits

__Loss of Hair All Over or Spots

__Facial Rash

Cardiovascular

__Raynaud's

__Fingers White, Purple, Blue in Cold

__Shortness of Breath while Lying Flat

__Heart Pounding

__Chest pain/Angina

x Heart Murmurs

x Swollen Legs or Feet

__Wake at Night to Sit Up and Catch Breath

Gastrointestinal

x Heartburn

__Trouble Swallowing

x Nausea

__Stomach Pain

__Diarrhea

__Constipation

__Blood in Stool

__Black/Tarry Stools

__Hepatitis

__Yellow Skin/Eyes

Neurological System

__Epilepsy/Seizures

__Muscle Weakness

__Headaches

__Dizziness

__Fainting

__Muscle Spasms

__Loss of Coordination

__Fainting Spells

__Numbness/Tingling Arms/Legs

Psychiatric

__Anxiety

__Depression

__Suicidal Thoughts

Genitourinary

__Burning while Urinating

__Urinating Frequently

__Kidney Stones

__Blood in Urine

x Night time Urination

__Prostate Troubles

x Miscarriages (Number: 4)

__Flank Pain

Patient Signature:_____ Date:_____

Physician Signature:_____ Date Reviewed:_____

Please list all of your physicians that you are authorizing us to release medical information/records to:

Physicians Name	Specialty
DR KAREN PRICE	PULMONLOGIST
DR ADAM GONZALEZ	FAMILY MEDICINE
DR RADHIKA M THORN	HEMATOLOGY AND ONCOLOGY
DR J PHILLIP REYNOLDS	ORTHOPAEDIC SURGERY
DR ANDREW CLARK	PHYSIATRIST

Patient Signature: _____ Date: 12/13/2023