

# ARTHRITIS SPECIALISTS, LTD.

## Patient Registration

FULL NAME <b>MARY LORRAINE CREWS</b>				S.S. NUMBER <b>578-64-1781</b>	
ADDRESS <b>8206 AMARA PL</b>				<b>CHESTERFIELD</b>	
BIRTH DATE <b>11/07/1947</b>		AGE <b>76</b>	<b>FEMALE</b>	MARRIAGE STATUS <b>MARRIED</b>	PR <b>864-404-8769</b>
LANGUAGE <b>ENGLISH</b>			RACE <b>HUMAN</b>		ETHNIC GROUP <b>AFRICAN AMERICAN</b>

EMPLOYER <b>RETIRED</b>	OCCUPATION
ADDRESS	BUSINESS PHONE

EMERGENCY CONTACT <b>OTIS J CREWS</b>	PHONE <b>301-467-8523</b>
ADDRESS (IF DIFFERENT FROM ABOVE)	

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

### Insurance Information (Name of Insurance Companies)

PRIMARY <b>MEDICARE</b>	SECONDARY <b>TRI-CARE 4 LIFE</b>	TERTIARY
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### 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.

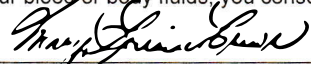
I give my permission for physicians and staff of Arthritis Specialists, Ltd. to leave voice mails on my home phone or work phone.

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

<input type="checkbox"/> Anxiety	<input checked="" type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input checked="" type="checkbox"/> Back Pain	<input checked="" type="checkbox"/> Cancer	<input type="checkbox"/> Chronic Renal Insufficiency
<input type="checkbox"/> Clots in Legs	<input type="checkbox"/> Clots in Lungs	<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> COPD	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes (Type I)	<input type="checkbox"/> Diabetes (Type II)	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Gout	<input checked="" type="checkbox"/> Glaucoma	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Disease – Angina	<input type="checkbox"/> Hepatitis
<input checked="" type="checkbox"/> High Cholesterol	<input checked="" type="checkbox"/> Hypertension	<input type="checkbox"/> Intestinal Bleeding
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Lupus	<input type="checkbox"/> Migraine Headache
<input type="checkbox"/> Osteoarthritis	<input checked="" type="checkbox"/> Osteopenia	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Peptic Ulcer Disease	<input type="checkbox"/> Prostate Trouble	<input checked="" type="checkbox"/> Reflux Heart Burn
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Sjogren's
<input type="checkbox"/> Strep Throat (Recent)	<input type="checkbox"/> Tension Headache	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Underactive Thyroid	<input type="checkbox"/> Urinary Tract Infection	
Other:(not listed above) <u>VENTRICULAR PREMATURE BEATS; MDS; CERVICAL CANCER; HIATAL HERNIA; DIVERTICULOSIS OF COLON; CHRONIC RENAL STAGE III</u>		

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

**COLONOSCOPY JUNE 2023**

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**ROBOTIC SIGMOID COLECTOMY SEPT 2022**

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**PARTIAL THYROIDECTOMY 2018**

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**ROTATOR CUFF REPAIR 2014**

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**HYSTRECTOMY; APPENDECTOMY 1989 AND PRIOR**

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## Current Medications, Dosage and Frequency

Medication

Dosage

\_\_\_ No Known Medication  
Frequency

<b>AZITHROMYCIN</b>	<b>250 MG</b>	<b>1/DAY</b>
<b>DICLOFENAC SOD EC</b>	<b>75 MG</b>	<b>2/DAY</b>
<b>ROSUVASTATIN</b>	<b>20 MG</b>	<b>1/DAY</b>
<b>METOPROLOL SUCCINATE ER</b>	<b>25 MG</b>	<b>1/DAY</b>
<b>AMLODIPINE BESYLATE</b>	<b>10 MG</b>	<b>1/DAY</b>
<b>OMEPRazole DR</b>	<b>40 MG</b>	<b>2/DAY</b>
<b>CITIRIZINE</b>	<b>10 MG</b>	<b>1/DAY</b>
<b>MICARDIS HCT</b>	<b>80 MG/ 12.5 MG</b>	<b>1/DAY</b>
<b>FLUTICASONE PROPIONATE NS SPR</b>	<b>50 MCG/16 GR</b>	<b>1/DAY</b>

## Vitamins

**VITAMIN D3; VITAMIN B COMPLEX WITH C; CO Q10**

## Allergies to Medications (Please include reaction if possible)

\_\_\_ No Known Drug Allergies

<b>SUCRALFATE</b>

## Social History

(☒) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed

Employment – Occupation **RETIRED**

Current Smoking Status: \_\_\_ Never Smoked \_\_\_ Smoke Every day \_\_\_ Smoke Some Days

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

Do you drink caffeinated beverages? ( ) No (☒) Yes Number per day? \_\_\_\_\_

Do you drink alcohol? (☒) No ( ) Yes Number per week? \_\_\_\_\_

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

## Family History (Please include relation if possible)

\_\_\_ No Known Family History

___ Ankylosing Spondylitis ( )	___ Arthritis ( )	___ Asthma ( )	___ Cancer ( <b>FATHER; BROTHER</b> )
___ Crohn's Disease ( )	___ Diabetes ( )	___ Epilepsy/Seizure ( )	___ Gout ( )
___ Heart Disease ( <b>MOTHER; BROTHER</b> )	___ High Blood Pressure ( <b>MOTHER; BROTHER</b> )	___ Kidney Disease ( )	___ Lupus or SLE ( )
___ Mental Illness ( )	___ Osteoarthritis ( )	___ Osteoporosis ( )	___ Psoriasis ( )
___ Psoriatic Arthritis ( )	___ Rheumatoid Arthritis ( )	___ Stroke ( <b>MOTHER; BROTHER</b> )	___ Tuberculosis ( )
___ Ulcerative Colitis ( )	Other: _____		

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

**Constitutional Symptoms**

☒ Recent Weight Gain  
Amount (lbs.) \_\_\_\_\_  
☐ Recent Weight Loss  
Amount (lbs.) \_\_\_\_\_  
☒ 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  
☒ Tender Scalp  
☐ Jaw Pain while Chewing Food

**Pulmonary**

☒ Coughing  
☐ Wheezing  
☐ Sputum Production  
☐ Shortness of Breath  
☐ Chest Pain with Deep Breath  
☐ Coughing Up Blood

**Musculoskeletal**

☐ Morning Stiffness  
How long \_\_\_\_\_  
☐ Joint Pain  
☐ Joint Swelling  
☒ Neck Pain  
☒ 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  
☒ 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
- ☒ Heart Murmurs
- ☒ Swollen Legs or Feet
- ☐ Wake at Night to Sit Up and Catch Breath

**Gastrointestinal**

- ☒ Heartburn
- ☐ Trouble Swallowing
- ☒ 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**

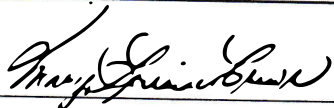
- ☐ Burning while Urinating
- ☐ Urinating Frequently
- ☐ Kidney Stones
- ☐ Blood in Urine
- ☒ Night time Urination
- ☐ Prostate Troubles
- ☒ Miscarriages (Number: 4)
- ☐ Flank Pain

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	PULMONOLOGIST
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