Wake Rheumatology & Osteoporosis Consultants, P.A.

3718 Benson Drive • Raleigh • NC 27609 • Phone (919) 872-9762 • Fax (919) 872-9797

Today's Date:__/__/__ Chart #_____

SS.#:___/___/___ Patient Name_____
First MI Last Suffix

Sex____ Birth Date: ___/___/____ Marital Status: S M D W

Race:_____ Employment Status:_____
(Native American, Caucasian, Black, Hispanic, Asian, Other)

Address_____
Street Apt City State Zip

Home Phone( )_____Work( )_____Other( )_____

Employer_____

Employer Address_____
Street Apt/Suite City State Zip

Emergency Contact_____
Name Relationship

Emergency Contact Phone Number ( ) _____

Referring Physician:_____Phone_____

Primary Care Physician_____Phone_____

Primary Insurance

Insurance Company_____ Phone( )_____

Claim Address_____
Street/P.O. Box City State Zip

Policy#_____ Group#_____

Name of policy holder_____ DOB__/__/__

Employer_____ Policy Holder SS#____/___/____

Secondary Insurance

Insurance Company_____ Phone( )_____

Claim Address_____
Street/P.O. Box City State Zip

Policy#_____ Group#_____

Name of Policy holder_____ DOB__/__/____

Employer_____ Policy Holder SS#_____/____/_____

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I authorize the attending physician to administer medical care as necessary. Wake Rheumatology & Osteoporosis Consultants, P.A. will file all insurance claims as a courtesy to me, their patient. I hereby authorize payment directly to Wake Rheumatology & Osteoporosis Consultants, P.A. for all medical services provided to me, for benefits otherwise payable to me. I understand that I am financially responsible to the physician for charges not covered by assignment. I understand that should it become necessary to pursue collections through an outside agency for unpaid medical services, I will be responsible for all reasonable collection and attorney fees.

I understand that Wake Rheumatology & Osteoporosis Consultants, P.A. expects me to pay all deductibles and co-pays at time of service. If I have no insurance, a payment plan may be worked out with a minimum down payment and monthly payment depending on the total amount due at time of service. Wake Rheumatology & Osteoporosis Consultants, P.A. will accept cash, checks or charge card payments. **There will be a $35 charge for all returned checks.**

I understand that Wake Rheumatology & Osteoporosis Consultants, P.A. telephone hours are Monday through Thursday 8:30am To 4:55pm and on Friday our office will be closed. I will make all non-emergency calls during these hours when my medical records are readily available. I understand that all non-emergency phone calls for the physician will be returned by the following business day. Very urgent or emergency calls are accepted at all hours. A service fee of $25.00 will be billed for non-urgent calls after hours.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Wake Rheumatology & Osteoporosis Consultants, P.A.:

- To file insurance claims for all services provided to me and I authorize payments for those services to be made directly to the provider;
- To release information about me to any referring physician or other provider or to any institution as necessary to provide treatment or diagnosis for me;
- And my physician or other provider(s) to release information about me as necessary to process claims for payment for services provided to me, including to health and liability insurance companies; agencies processing Medicare claims, medical benefit plans, case managers or reviewers, or third parties responsible for paying claims for services provided to me.

I certify that I understand and agree to the above releases and assignment of benefits.

I have received notice of this organization's privacy practices.

Patient's signature_____Date_____

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PRIMARY CARE PHYSICIAN INFORMATION

Last Name:_____ First Name:_____

Practice Name:_____

Street Address:_____ City:_____ St:_____ Zip:_____

Phone:_____ Fax:_____

Email Address:_____

REFERRING PHYSICIAN INFORMATION

Same As Above:

Last Name:_____ First Name:_____

Practice Name:_____

Street Address:_____ City:_____ St:_____ Zip:_____

Phone:_____ Fax:_____

Email Address:_____

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PATIENT HISTORY FORM

PERSONAL INFORMATION

Last Name_____ First Name_____ MI____

Date of First Appointment: _____ Sex: ☐ M ☐ F Date of Birth_____

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

PRESENT SYMPTOMS

Description of Current Symptoms: _____

_____

Date Symptoms Began: _____

PAST MEDICAL HISTORY

Do you now or have you ever had: *(check if "yes")*

☐ Anemia	☐ Cancer	☐ Diabetes	☐ High Blood Pressure
☐ Depression	☐ Stomach Ulcers	☐ Kidney Disease	☐ Stroke
☐ Glaucoma	☐ Psoriasis	☐ Colitis	☐ Tuberculosis
☐ Rheumatic Fever	☐ Thyroid Disease	☐ Heart Problems	☐ Lung Problems

Other Illness (*please list*): _____

_____

Natural or Alternative Therapies (*chiropractic, magnets, massage, over-the-counter preparations, etc.*)

_____

_____

Wake ROC

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SOCIAL HISTORY

Do you drink Caffinated beverages?	☐ Yes	☐ No	If yes cups/glasses per day? _____
Do you Smoke?	☐ Yes	☐ No	If yes how many packs per day? _____
Do you drink Alcohol?	☐ Yes	☐ No	If yes how much? _____
Do you exercise regularly?	☐ Yes	☐ No	If yes, type and how many hrs per week? _____
Do you get enough sleep at night?	☐ Yes	☐ No	How many hours? _____
Do you wake up feeling rested?	☐ Yes	☐ No	

MEDICATIONS

Drug Allergies: ☐ No ☐ Yes If yes, to What? _____

_____

Type of reaction: _____

Present Medications (*List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.*)

	Name of Drug	Dose (include strength & number of pills per day)
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Please check this box if additional medications are listed on the back of this sheet ☐