PATIENT REGISTRATION
TRISTATE ARTHRITIS & RHEUMATOLOGY

Arthur M. Kunath MD _____
Kerrin D. Burte MD _____
Joseph E. Temming MD _____

Liza R. Varghese MD _____
C. Lee Colglazier MD _____
Malini Juyal MD _____

PATIENT INFORMATION (PLEASE PRINT)

Name_____Birthdate_____SS#_____

Address_____City_____State_____ Zip_____

Home Phone (____)_____Work Phone (____) _____ Cell Phone (____) _____

Sex: M___F___ Age: ____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact Name : _____Phone Number: _____

INSURANCE INFORMATION (IF YOU WANT YOUR INSURANCE SUBMITTED BY OUR OFFICE, PLEASE FILL OUT THIS ENTIRE SECTION**)**

	PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name Insurance Co.....1)	_____	2) _____
Address.....1)	_____	2) _____
	_____	_____
Subscriber's ID#.....1)	_____	2) _____
Subscriber's Group # .....1)	_____	2) _____
Subscriber's Name.....1)	_____	2) _____
Subscriber's SS#.....1)	_____	2)_____
Subscriber's D.O.B……....1) Sex M____F_____	_____	2) _____

Patient Relationship.....1) ____SELF _____SPOUSE ____CHILD 2) ____SELF ____SPOUSE ____CHILD

(Please give the name of your doctor, not the name of the practice)

Referring Doctor_____ Family Doctor_____

Address_____ Address_____

Phone No._____ Phone No._____

RELEASE OF PROTECTED HEALTH INFORMATION AND PAYMENT FOR SERVICES: I authorize the use and disclosure of protected health information and other demographic information to carry out treatment, payment and health care operations. Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures. I authorize the assignment and payment of my insurance benefits to the physicians of Tristate Arthritis & Rheumatology,MD to include government services. If my insurance plan does not cover the medical services or does not pay for certain services or goods as benefits, I agree that I am financially responsible. Also, I understand that I AM RESPONSIBLE FOR ANY REFERRALS REQUIRED BY MY INSURANCE COMPANY, ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY BALANCE NOT PAID FOR BY MY INSURANCE.

_____

*******SIGNATURE********** DATE

NAME: _____

LIST ALL ALLERGIES TO MEDICATIONS:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

LIST ALL CURRENT MEDICATIONS:

NAME/DOSE/HOW OFTEN	NAME/DOSE/HOW OFTEN	NAME/DOSE/HOW OFTEN
1.	8.	15.
2.	9.	16.
3.	10.	17.
4.	11.	18.
5.	12.	19.
6.	13.	20.
7.	14.	21.

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING (please circle all that apply)

Alcoholism	Lung Disease	Anorexia	Lupus	Asthma
Osteoarthritis	Blood Clots	Osteoporosis	Cancer	Psoriasis
Diabetes	Scleroderma	Depression	Gout	Rheumatoid Arthritis
Stroke	Hay Fever	TIA	Hepatitis	Thyroid Problems
Tuberculosis	Ulcers	Kidney Disease	Liver Disease	Hypertension (high blood pressure)
Drug Abuse	Irritable Bowel/Colitis	Heart Disease/Heart Attack		

Smoking (How Long _____)

DOES ANY MEMBER OF YOUR FAMILY HAVE A HISTORY OF ANY (please circle all that apply)

Cancer	Osteoarthritis	Depression	Diabetes	Psoriasis
Gout	Lupus	Scleroderma	Rheumatoid Arthritis	Heart Disease/Heart Attack

PREVIOUS SURGERIES

_____

_____

PLEASE EXPLAIN IN DETAIL WHAT YOU ARE BEING SEEN FOR TODAY

_____

_____

Tristate Arthritis and Rheumatology

Multidimensional Health Assessment Questionnaire (MDHAQ)

YOUR NAME:_____ **Today's Date:**_____

1. Please check (✓) the **ONE** best answer for your abilities at this time:

OVER THE PAST WEEK, were you able to:	Without **ANY** difficulty	With **SOME** difficulty	With **MUCH** difficulty	**UNABLE** to do
Dress yourself, including tying shoelaces, doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of a car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
Walk two miles?	☐ 0	☐ 1	☐ 2	☐ 3
Participate in sports and games as you would like?	☐ 0	☐ 1	☐ 2	☐ 3

2. How much pain have you had because of your condition **OVER THE PAST WEEK?** Please indicate below how severe your pain has been:

NO PAIN ○○○○○○○○○○○○○○○○○○○○ **PAIN AS BAD AS IT COULD BE**

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

3. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL ○○○○○○○○○○○○○○○○○○○○ **VERY POORLY**

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

4. Please describe any recent pain, discomfort, or other symptoms today:

_____

_____

5. Please circle if you have had any of the following symptoms recently:
fever, weight loss, rash, weakness, nausea, vomiting, abdominal pain, blood in the stool, chest pain, cough, shortness of breath
Please explain if any of the above are circled:

_____

_____

6. Please explain if you have had any developments or changes in your medical conditions, medications, allergies, or family history:

_____

_____

MD Signature_____ Date_____

OFFICE USE

FN 0-30 ☐

FN 0-10 ☐

PN 0-10 ☐

PTGL 0-10 ☐

RAPID3 0-30 ☐

RAPID3 0-10 ☐

Updated as of July, 2012

Tristate Arthritis and Rheumatology
Controlled Substance Prescription Policy and Consent
Updated to be in compliance of Kentucky House Bill 1, 2012

The following policy applies to the prescribing of controlled substances.

-All patients receiving controlled substance medication must sign a controlled substance consent form.

-The use of any controlled substance involves a risk including but not limited to tolerance, dependence, and addiction. A controlled substance should only be obtained after a careful discussion of the risks and benefits with the prescribing physician. Although it might be determined that the benefits outweigh the risks, it is understood that any dose or frequency of any type of controlled substance still involves a risk of addiction.

-The use of any controlled substance can cause an alteration of mental status, including but not limited to drowsiness, confusion, lightheadedness, and slowed reflexes, which can increase the risk of falls and decreased performance. Patients receiving a controlled substance agree to refrain from any activity, such as operating a motor vehicle, which can put themselves or others at risk. The use of other mental status altering medications or substances (such as alcohol) in combination can increase the overall risk of complications and should be avoided.

-Initial controlled substance prescriptions cannot be given without a face-to-face visit.

-Prescriptions cannot be refilled without a face-to-face physician visit at minimum every three months, at which time the physician is required by law to query the Kentucky All Schedules Prescription Electronic Reporting (KASPER) System.

-It is the responsibility of the patient to schedule routine follow up appointments in advance for refills. Failure to schedule an appointment, or cancelling an appointment, does not constitute an emergency appointment for refills.

-At the time of the visit, a patient will be given enough medication to last until the next physician visit or nurse refill visit**. IF A PATIENT FEELS THE MEDICATION REGIMEN IS INADEQUATE, OR HAS A SIDE EFFECT, THE ISSUE MUST BE ADDRESSED IN PERSON DURING A FACE-TO-FACE VISIT. NO CHANGES TO THE REGIMEN WILL BE MADE OVER THE PHONE. IF A PATIENT ALTERS THE PRESCRIBED REGIMEN WITHOUT PHYSICIAN INSTRUCTION AND RUNS OUT EARLY, NO EARLY REFILLS OR ADDITIONAL MEDICATION WILL BE GIVEN, AND THE PATIENT WILL HAVE TO WAIT FOR AN APPOINTMENT FOR ANY ADDITIONAL INTERVENTION.**

-**RUNNING OUT OF PAIN MEDICATION EARLY DUE TO INAPPROPRIATELY TAKING THE MEDICATION DOES NOT CONSTITUTE AN EMERGENCY APPOINTMENT.** If no appointments are available, a patient must either wait for an appointment or go to the emergency room.

-The patient is responsible for finding out on what days and times the office is open**. NO CONTROLLED SUBSTANCES WILL BE PRESCRIBED WHEN THE OFFICE IS CLOSED BY THE ON CALL PHYSICIAN.**

-The patient is responsible for their medications and prescriptions at all times. **EARLY REFILLS AND REPLACEMENT PRESCRIPTIONS WILL NOT BE GIVEN FOR LOST, STOLEN, OR DAMAGED MEDICATIONS OR PRESCRIPTIONS.**

-Any complications, including the loss of a prescription, involving a mail order pharmacy is to be resolved by the patient and the mail order pharmacy. **WE ARE NOT RESPONSIBLE FOR THE LOSS OF A PRESCRIPTION BY THE MAIL, OR FOR THE LOSS OF A PRESCRIPTION BY THE MAIL ORDER PHARMACY.**

-All prescriptions for controlled substances should be filled at one pharmacy.

-Tristate Arthritis and Rheumatology will only prescribe controlled substances to patients who have not been diagnosed with, treated for, or arrested for substance abuse or addiction. Signing this agreement is an attestation that a patient has never been involved in the sale, illegal possession, dispersion, or transport of controlled substances, or been discharged by another physician for violating a controlled substance contract.

-Controlled substances are only to be taken unaltered by the patient to whom they have been prescribed following the prescribed directions. Medications cannot be given to others.

-Patients receiving controlled substances agree to allow physicians at this office to discuss his or her care freely with other treating physicians, including sending a copy of office notes.

-Patients who are prescribed controlled substances by Tristate Arthritis and Rheumatology will not receive controlled substances by other physicians, except in cases of emergency in which case they will notify the office. Patients also allow the office to randomly check bodily fluids and pill counts as part of recommended screening protocols.

-Female patients treated with controlled substances including narcotic pain medication understand side effects to an unborn baby are possible and will certify they are not pregnant before taking controlled substances including narcotic pain medications.

-Tristate Arthritis and Rheumatology reserves the right to discontinue treatment with controlled substances if it is reasonably suspected that a patient has not been compliant with the controlled substance contract.

By signing below, I certify that I have read, and agree to abide by the office policy.

_____

Patient Signature

_____

Printed Patient Name

_____

Date

_____

Witness