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TO: OUR PATIENTS

REGARDING: CHECK-IN AND CHECK-OUT PROCEDURES
CO-PAYMENT

RALI has procedures for check-in, check-out, return visit scheduling, and co-payment collection. At the check-in desk, the staff member will present you with a copy of your:

1) **Patient Information Sheet. You will be asked to review the information and to be certain that it is correct. If the information needs to be updated, please inform the staff at that time. If there is no need to make corrections you will be asked to sign off on the sheet we will do this at every visit. We recognize that this may seem repetitious to those of you whose information remains unchanged. Our staff handles approximately 100 pieces of return mail a week from patients whose information has changed. Thus, we are taking these steps to ensure our ability to communicate with you, and on your behalf when necessary.**

2) **At the check-in desk, you will also be reminded that a co-payment is due at the time of your visit, and the co-payment will be collected at the check-out. Collection of co-payments be the office is required by both insurers and by Medicare. RALI does not make Medicare or insurance company law, or insurance company policy. The check-in and check-out staff is not empowered to make exceptions to co-payment collection policy. When your insurance plan requires a referral for you to see one of the doctors, we must have that referral or we may be forced to re-schedule your visit.**

3) **You must visit the check-out desk before leaving the office. The check-out desk will schedule your return visit. The scheduling of return visits is to be done at the time of check-put. We ask for your cooperation in the regard.**

PATIENT INFORMATION

DATE_____

NAME_____
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS_____CITY_____ ZIP_____

EMAIL ADDRESS_____

HOME PHONE_____CELL PHONE_____

MARTIAL STATUS S_____M_____W_____D_____ BIRTHDATE_____ AGE_____

Due to recent legislation changes, the government is requiring medical facilities to collect the following information.
Please circle all that applies

Ethnicity/Race	Ethnic Group
Black or African American	Not Hispanic or Latino
Hispanic/Latino	
White/Caucasian	

RFERRING DOCTOR_____TEL#_____NPI#_____

EMPLOYER NAME_____OCCUPATION_____PHONE#_____

WORK ADDRESS_____CITY_____ZIP_____

NAME OF SPOUSE_____
(LAST) (FIRST) (MIDDLE INITIAL)

SOUPSE'S EMPLOYER_____OCCUPATION_____PHONE#_____

WORK ADDRESS_____CITY_____ZIP_____

IN CASE OF AN EMERGENCEY NOTIFY/RELATIONSHIP_____PHONE#_____

RETAIL PHARMACY_____PHONE #_____

MAIL ORDER PHARMACY _____PHONE #_____

PRIMARY INSURED_____ INSURANCE COMPANY_____

ID #_____ GROUP #_____

SECONDARY INSURED_____INSURANCE COMPANY_____

ID#_____GROUP#_____

ASSIGNMENT OF BENEFITS	RELEASE OF INFORMATION
I authorize payment of medical benefits to myself Or the named provider for professional services rendered	I authorize the release of any medical information Necessary to process this claim
SIGNED_____DATE_____ (Subscriber)	SIGNED_____DATE_____ (Subscriber)

I have reviewed the above information and there are no changes at this time.

Initials Date Initials Date Initials Date Initials Date Initials Date Initials Date Initials Date
_____ ____ _____ ____ _____ ____ _____ ____ _____ ____ _____ ____ _____ ____ _____ ____

Patient Name_____ Date_____

Please fill in names of all doctors next to their Specialty

Allergist

Cardiologist

Chiropractor

Dermatologist

Endocrinologist

ENT

Gastroenterologist

Nephrologist

Neurologist

OB/GYN

Oncologist/Hematologist

Ophthalmologist

Orthopedist

Pain Management

Family Doctor/PCP/Internist

Psychiatrist

Psychologist

Pulmonologist

Urologist

Vascular

Today's Date_____

Office use only: Physician Reviewed: ☐

Revised 9.22.16

Health History Questionnaire

All Questions contained in this questionnaire are strictly confidential and will become part of your medical record

Last Name: _____ First Name: _____
DOB: _____

F ☐
M ☐

Allergies

(Medication or Other)

Check here if none ☐

Please list any allergy	Reaction you had

Medications

(List your prescribed drugs and over the counter drugs, such as vitamins)

Name of drug	Strength	Frequency	Start date (if known)

Past Medications

Please review this list of arthritis medications. Check circle any that you have taken in the PAST

Anti-Inflammatories (NSAIDs) & Steriods
Arthrotec
Celebrex
Clinoril/Sulinda
Daypro/Oxaprozin
Dolobid Diflunisal
Feldene/Piroxicam
Indocin
Lodine/Etodolac
Motrin/Ibuprofen/Aleve
Naprosyn
Ketoprofen
Voltaren/Diclofenac
Other:

Rheumatic Biologics
Actemra
Cimzia
Enbrel
Humira
Orencia
Remicade
Rituxan
Simponi Aria
Benlysta
Stelara
Cosentyx
Other:

Pain Relievers/Narcotics
Hydrocodone
Oxycodone
Codeine
Fentanyl
Dilaudid
Methamphetamine
Methadone
Demerol
Dexedrine
Other:

Fibromyalgia Medication
Lyrica
Cymbalta
Savella
Gabapentine/Neurotin
Tramadol/Ultram/Ultracet
Cyclobenzaprine
Nortriptyline
Amitriptyline/Elavil
Other:

Disease Modifying Anti-Rheumatic Drugs (DMARDS)
Arava (leflunomide)
Cytoxan (Cyclophosphamide)
Xeljanz/Tofacitinib
Otezla
Imuran(Azathioorine)
Methotrexate (Rheumatrex)
Neoral (Cyclosporine)
Plaquenil (Hydroxychloriquine)
Prednisone/ Cortisone
Sulfasalazine (Azulfidine)
Other:

Osteoporosis
Fosamax/Alendronate
Actonel/Risedronate
Boniva/Ibandronic acid
Zoledronic acid/Reclast
Prolia
Atelvia
Estrogen
Evista/Raloxfiene
Forteo
Other:

Gout Medication
Clochicine
Uloric
Krystexxa
Probenecid
Lopurin/ Allopurinol
Other:

Knee Injections
Orthovisc
Synvisc
Euflexxa
Hyalgan
Supartz
Other:

Please list any other past medications your doctor should aware of:
_____
_____

Last Name:_____ **First Name**_____

Personal Health History

Circle any health problems that other doctors have diagnosed you with

Arthritis	**GERD**
Asthma	**Heart problems _____(type)**
Cancer_____(type)	**Hepatitis A,B, or C**
Cataract	**High blood pressure**
Blood Clot	**Kidney Problems**
Colitis	**Osteoarthritis**
COPD	**Pneumonia**
Depression	**Seizures**
Diabetes I or II	**Stroke**
High Cholesterol	**Depression**
Emphysema	**Thyroid problems: Hypo/Hyper**
Fibromyalgia	**Bone Fracture**
Anxiety	**TB/Positive PPD**

Surgical History

Date	**Procedure**

Last Name: _____First Name: _____

Family Health History

Family Member	Age if Alive	Age at Death	Significant Health Problems/Cause of Death
Father			
Mother			
Sibling (Male/Female)			
Sibling (Male/Female)			
Sibling (Male/Female)			
Sibling (Male/Female)			
Sibling (Male/Female)			

Child (Male/Female)	D.O.B	Age at Death	Significant Health Problems/Cause of Death

Last Name:_____ **First Name:**_____

Social History

Marital Status:

Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Exercise:

None

Type:_____

Frequency:_____ per week

Caffeine:

None ☐ Coffee ☐ Tea ☐ Cola ☐

# of Cups per Day

Tobacco:

Yes ☐ No ☐

Cigarettes ☐ Cigars ☐

# of years_____ or Year that you Quit_____

Alcohol:

Yes ☐ No ☐

How many drinks per week?_____

Recreational drugs: *(non-medical)*

Yes ☐ No ☐

If yes please list:_____

Last Name: _____ First Name: _____

RHEUMATOLOGY ASSOCIATES OF LONG ISLAND

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Fax: (631) 928-2944	Fax: (631) 979-1609	Fax: (631) 979-1609	Fax: (631) 9791609	Fax: (718) 698- 8777

Name_____ Account_____

Notification Policy

It is our policy not to release confidential and/or unauthorized information by home telephone, answering Machine, work telephone, voice mail, cell phone/ or pager. When returning calls and an answering machine picks up; we do not leave a message unless it is an appointment reminder. Information also will not be left with an unauthorized person who may answer the phone.

If you would like to have information released to someone other than yourself, please complete the following:

I authorize the staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

___yes ___no Home telephone_____

___yes ___no Home Answering Machine_____

___yes ___no Fax Home_____

___ yes ___no Fax Work_____

___yes ___no Work phone/Voicemail_____

___yes ___no Cell phone/Voicemail_____

___yes ___no E-mail_____

___yes ___no Pager_____

Please list names of authorized people we may leave messages with (i.e. spouse, boyfriend, girlfriend, parent, grandparent etc.):

Name_____ Relationship_____ yes __ no__
Name_____ Relationship_____ yes __ no__
Name_____Relationship_____ yes __ no__

Who may we discuss your financial situation with?

Name_____Relationship_____ yes__ no__
Name_____Relationship_____ yes__ no__

_____ _____
SIGNATURE (Patient/Guardian) **DATE**