Rheumatology Express

724 Maiden Choice Lane,
Suite 201,
Catonsville MD
Tel: 410-650-4121
Fax: 877-763-4971

NEW PATIENT REGISTRATION FORM

Dear Patient,

Please complete this form to the best of your knowledge. This is to ensure a fast appointment process with us. We can try to enter information in your electronic chart and also try to obtain your medical record. We would also like to verify your insurance benefits before your visit to the office. Thank you.

1-PATIENT INFORMATION				
Last Name First Name MI			Sex:	Home Phone:
Address:			Social Security#	
City, State:	Zip:	DOB:		Marital Status:
Employer Info:		Job Title:		Work Phone:
Name and phone number of emergency Contact:				
Email address:		Cell Phone:		May we correspond by email? ☐Yes ☐No
Please specify Ethnicity: _____ ☐ Hispanic ☐ Non- Hispanic ☐ Language: _____ Race: ☐ White ☐ Black ☐ Hispanic ☐ Other: _____				
2-PRIMARY CARE PHYSICIAN INFORMATION				
Referred by:		Reason for referral:		
Address:			Office phone: Office Fax:	
3-REFERRING PHYSICIAN INFORMATION				
Referred by:		Reason for referral:		
Address:			Office phone: Office Fax:	
4-YOUR PRIMARY INSURANCE				
☐ Medicare ☐PPO ☐HMO				

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5-FINANCIAL RESPONSABILITY		
Name of person financially responsible:	DOB:	Relation to patient:
Address:	Social Security	Phone:

6- INSURANCE INFO

Primary Insurance Name, ID Number, Group Number

Name of Insured person, DOB, Phone, address, relation to patient

7- MEDICAL HISTORY

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

☐ Anemia
☐ Arthritis
☐Asthma
☐ Bleeding/ Blood Disorder
☐ Breasts cancer
☐ Cancer: _____
☐ Cataracts
☐ Colitis
☐ Depression
☐ Constipation
☐ Emotional/Mental Illness
☐ Emphysema
☐ Epilepsy/seizures
☐ Glaucoma
☐ Hay Fever
☐ Heart Problems
☐ Hepatitis Jaundice
☐ High Blood pressure
☐ HIV/AIDS
☐ Lupus
☐ Polymyalgia Rheumatica (PMR)
☐ Kidney Stones
☐ Liver disease
☐ Osteoporosis
☐ Migraine Headache
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis/TB
☐ Rheumatoid Arthritis
☐ Other: _____

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8- SURGICAL HISTORY

Surgical Procedures /Serious Injuries /Ilnesses	Year	Physician	Hospital

☐ Have you been hospitalized in the past year, if so why?_____

Any Previous Fractures ? ☐Yes ☐No Describe: _____

Any other serious injuries? ☐Yes ☐No Describe: _____

9- MEDICATIONS

Pharmacy Name: _____ Phone: _____ Fax: _____

Address: _____

List all medications you are currently taking which have been ordered by a doctor (including inhalers)and all over the counter drugs. Please list prescribed medication first .. right side describe medication you have stop using and why.

Name of Medicine/Dose/ Frequency	Medicine you stop using WHY
1.	1.
2.	2.
3.	3.
4.	4.

10- ALLERGIES

☐ Medications/ list describe: _____

☐ Food ☐ Animals ☐ Latex ☐ Tape ☐ pollen ☐ Eggs ☐ iodine ☐ Nuts

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11-SOCIAL HISTORY

Patient's Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Prefer not disclose ☐No. of Children

Do you drink caffeinated beverages? ☐Yes ☐No Cups/glasses per day? _____

Do you Smoke? ☐ Never ☐ Past ☐ Current? ☐ Cigarettes ☐ Tobacco
Year quit? _____ Number of years' smoke? _____Average packs day/week? _____

Do you drink alcohol? ☐Yes ☐No Number per week____ Do you drink every day? ☐Yes ☐ no
Has anyone ever told you to cut down on your drinking? ☐Yes ☐ no
Have you evert thought you have a problem with drinking? ☐Yes ☐ no

Do you use drugs for reasons that are not medical? ☐Yes ☐No If Yes, please list: _____

Your most recent Height _____ Weight: _____

12 - FAMILY HISTORY

Do you know any relatives who had: (Check and give relationship)?

☐ Cancer_____ ☐ Heart Problems_____ ☐Asthma_____ ☐ Goiter _____ ☐ Leukemia _____	☐ Rheumatic Fever _____ ☐ Diabetes _____ ☐ Epilepsy _____ ☐ Tuberculosis_____ ☐ Cataracts_____	☐ Glaucoma _____ ☐ Kidney Disease _____ ☐ Pneumonia _____ ☐ Psoriasis _____ ☐ Stroke _____	☐ High Blood Pressure _____ ☐ Anemia_____ ☐ HIV/AIDS _____ ☐ Emphysema _____ ☐ Colitis _____

Patient's Name: _____ Date: _____ Physician initials:_____