Greenwich Medical P.C.
PATIENT DEMOGRAPHICS FORM

Please Print

Patient name:_____
Last First Middle

Address:_____
Number Street Apt# State Zip code

Home phone: _____Work:_____Cell:_____

Email address:_____ Date Of Birth:_____

Social Sec #:_____ Sex:_____ Age:_____
Marital Status: SINGLE MARRIED DIVORCED WIDOWED
Student? Y or N If yes, part or full time; School name:_____

Person Insured:_____ Relationship to patient:_____
Address of Insured:_____
Number Street Apt# City State Zip code

Social Sec #:_____ DOB:_____ Phone#:_____
Person Insured's Employer and Address:_____
_____

Primary Insurance Information:
Information needs to be completed

Secondary Insurance Information:

INSURANCE_____ **Ins**_____
ID#_____ **ID#**_____

GROUP#_____**Group#**_____

Reason for visit_____
Accident related? Yes or No If Yes, auto work related_____
Who is your Primary care doctor?_____
Emergency contact:_____
Name Phone Relation

ASSIGNMENT & RELEASE: I hereby authorize my insurance benefits to be paid directly to Greenwich Medical and I am financially responsible for any non-covered services. I also authorize Greenwich Medical to release any information required in the processing of all my claims.

SIGNATURE:_____**DATE:**_____

Greenwich Medical, P.C.

Arthritis, Lupus, Osteoporosis & related disorders

Ndudi O. Oparaeche, MD

Office Hours: 8:00 AM to 5:00 PM, Monday, Tuesday, Wednesday, Thursday and Friday.

We are closed for lunch from 12:00 to 1:30 PM, phones are turned over at that time. The phone lines are open from 8:00 AM to 12:00 PM and 1:30 PM to 5:00 PM.

Note: Dr. Oparaeche is out of the office on Thursdays.

Parking is located in large parking areas directly across and around our office building. Reserved parking for disabled individuals is located close to the main lobby doors.

The following is a list of general office procedures and policies. Please feel free to ask about any questions or concerns you may have.

1) There is always a physician on call when our office is closed. Please use this service for non-life threatening emergencies to be referred to the appropriate facility for medical advice, treatment and follow-up. If you have a life threatening emergency, always call 911.

2) All patients are recommended to follow set protocols for their individual diagnosis (i.e. labs, x-rays and all other recommended procedures).

3) 24-hour notice is required for cancellation of an appointment. ***If an appointment is canceled less than 24 hours in advance, a $50 fee will be assessed that is not billable to insurance.*** Extenuating circumstances will be taken into consideration. A $75.00 fee will be assessed for no call, no shows. This is the patient's responsibility, insurance will not be billed.

4) Our office operates by appointment only. ***If you arrive more than ten minutes late for your scheduled appointment time, you may be asked to reschedule***.

5) If you have ***more than 3 cancellations/missed/rescheduled appointments***, it is at the Physician's discretion as to whether they will continue to see you.

6) Medication refills need to be phoned into your pharmacy ***48 hours*** in advance. Refills will be handled during office hours only. The on-call doctor will not refill medication.

7) Mail-away (90-day) prescriptions ***will not*** be called in by our office staff due to telephone hold times of 30-45 minutes. You can contact your pharmacy and have them fax us a request which we will fax back to them OR we will mail you a 90-day prescription that you can mail to your pharmacy. Please contact us 2-3 weeks prior to when you are in need of your medications.

8) It is the patient's responsibility to have a current referral or pre-certification for the services rendered at each visit. To avoid complications or misunderstandings, we ask that you arrange for a hard copy of the referral or a phone call from your primary care physician's office to be forwarded to our office prior to your visit.

9) Our office is Medicare non-assignment. Payment is due at the time of service.

10) ***Copay is due at the time of service. A $5 per month surcharge will be added for unpaid copay.***.

11) There will be a $45.00 fee assessed for all returned checks.

Sincerely,

Greenwich Medical, P.C.

Patient's Signature_____Date_____

Office: 9570 South Kingston Court Ste 220 Englewood, CO 80112
Phone: 303-515-2912 **Fax**: 303-955-6660

Greenwich Medical, P.C.

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

1. I grant permission to Greenwich Medical, P.C. to disclose health information of the following individual as specified below:

Patient Name: _____

Preferred Name: _____

2. I authorize the information to be disclosed as specified below:

☐ On my voicemail/answering machine at home _____ (specify phone #)
☐ On my voicemail/answering machine at work _____ (specify phone #)
☐ On my voicemail on mobile phone _____ (specify phone #)

☐ To the following family member(s) or other person(s):

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

3. The type and amount of information to be disclosed is as follows:

Any information about the patient's treatment* OR:

☐ Laboratory results
☐ X-Ray reports
☐ Medical instructions or advice
☐ Prescription drug information

☐ Appointment information, including confirmation/cancellation of appointments

☐ Other (specify) _____

*I understand that this may include detailed personal medical information including medical services to be provided as well as any information listed in #3 above.

Signature of Patient or Authorized Personal Representative (Please attach applicable legal documentation of authority)	Print Name	Date
_____	_____	_____

This consent form will expire when revoked by the patient/representative.

RHEUMATOLOGY PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: ____/____/____
Last First M. I.

Age: _____ Sex F M

Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/significant other

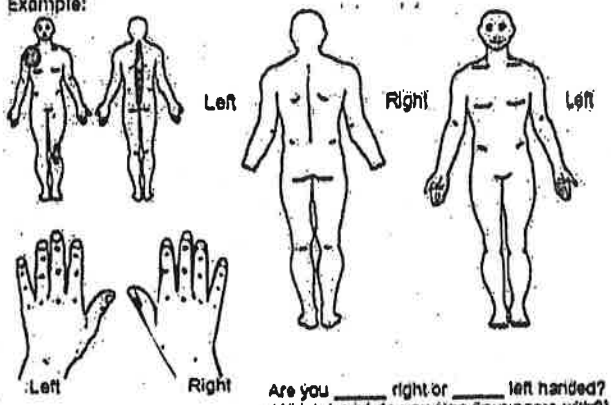
Whom do we thank for referring you here? _____

Name of your primary care physician: _____

Describe briefly your present symptoms: _____

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:



Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

When did your symptoms start? _____

What diagnosis have you been given, if any?

Please list the names of other practitioners you have seen for this problem: _____

Previous treatment for this problem (include physical therapy, surgery, and injections; medications to be listed later):

Physician initials _____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

	Yourself	Relative	→	Name/relationship
Arthritis (type unknown)	☐	☐	→	
Osteoarthritis	☐	☐	→	
Rheumatoid arthritis	☐	☐	→	
Gout	☐	☐	→	
Lupus or "SLE"	☐	☐	→	
Ankylosing spondylitis	☐	☐	→	
Childhood arthritis	☐	☐	→	
Sjogren's syndrome	☐	☐	→	
Osteoporosis	☐	☐	→	
Psoriasis/psoriatic arthritis	☐	☐	→	

PAST MEDICAL HISTORY

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

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Cancer (type) _____
- ☐ Leukemia
- ☐ Psoriasis
- ☐ Angina
- ☐ Heart problems
- ☐ Heart murmur
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Epilepsy (seizures)
- ☐ Cataracts
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach or peptic ulcer
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ HIV/AIDS

Other significant illnesses (please list): _____

Previous Operations

	Type	*Year*	*Reason*
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Any previous fractures? ☐ No ☐ Yes Describe _____

Any other serious injuries? ☐ No ☐ Yes Describe _____

Do you smoke? ☐ Yes – How much? _____ ☐ No ☐ In the past - How long ago? _____

Do you drink alcohol? ☐ No ☐ Yes : Usual drink: _____ How much: _____

Has anyone ever told you to cut down on your drinking ☐ Yes ☐ No

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

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

Physician initials _____

MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? _____

_____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	Dose (Include strength and number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

What medications have you taken previously? _____

PERSONAL HISTORY

What is your highest educational level? ☐ High school ☐ Some college courses ☐ College graduate ☐ Advanced degree

What is your current or past occupation? _____

Are you currently working? ☐ Yes ☐ No If yes, hours/week _____ If not, are you ☐ retired ☐ disabled ☐ sick leave?

Do you receive disability or SSI? ☐ Yes ☐ No If yes, for what disability? _____

What date did this disability begin? _____

With whom do you currently live? _____

How much exercise do you get each week? _____ What kind of exercise? _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of siblings: _____ Number living _____

Number of children _____ Number living _____ List ages of each _____

Health of children: _____

_____

Physician initials _____

SYSTEMS REVIEW

Date of last eye exam _____ Date of last chest x-ray _____

Date of last bone density test _____

Result of last TB (PPD) test: ☐ Never done ☐ Negative ☐ Positive Date test performed: _____

GENERAL
- ☐ Recent weight gain; how much ____
- ☐ Recent weight loss; how much ____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

MUSCLE/JOINTS/BONES
- ☐ Morning stiffness
  Lasting how long ___ Minutes ___ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Joint swelling

List joints affected in the last 6 months

_____

_____

_____

_____

EARS
- ☐ Ringing in ears
- ☐ Loss of hearing

EYES
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye

MOUTH
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness
- ☐ Recent increase in tooth cavities

NOSE
- ☐ Nosebleeds
- ☐ Loss of smell

THROAT
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain in jaw while chewing

NECK
- ☐ Swollen glands
- ☐ Tender glands

HEART AND LUNGS
- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing

STOMACH AND INTESTINES
- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain relieved by food
- ☐ Vomiting of blood/"coffee grounds"
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools

KIDNEY/URINE/BLADDER
- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Frequent urination
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

BLOOD
- ☐ Anemia
- ☐ Bleeding tendency

SKIN
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive
- ☐ Skin tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Numbness or tingling in hands/feet
- ☐ Memory loss
- ☐ Muscle weakness

PSYCHIATRIC
- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

For women only:

Age when periods began: _____

Number of pregnancies: _____

Number of miscarriages: _____

Have you reached menopause?

☐ No ☐ Yes If yes, at what age: ____

Date of last Pap smear: _____

Date of last mammogram: _____

If you are still having periods:

Are they regular? ☐ Yes ☐ No

How many days apart? _____

Physician initials _____

CORRONA modified HEALTH ASSESSMENT (mHAQ)
PATIENT QUESTIONNAIRE

PAGE 1 of 1 Site ID _____

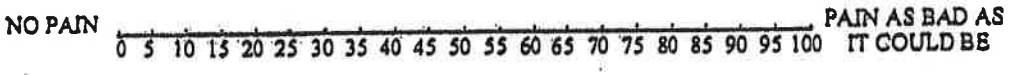
Patient ID _____-_____-_____ Date _____

Please mark the one response which best describes your usual abilities over the past few days:

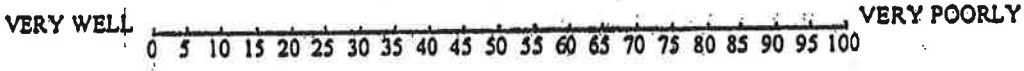
	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE to do
1.) Dress yourself, including tying shoelaces and doing buttons?	_____	_____	_____	_____
2.) Get in and out of bed?	_____	_____	_____	_____
3.) Lift a full cup or glass to your mouth?	_____	_____	_____	_____
4.) Walk outdoors on flat ground?	_____	_____	_____	_____
5.) Wash and dry your entire body?	_____	_____	_____	_____
6.) Bend down and pick up clothing from the floor?	_____	_____	_____	_____
7.) Turn regular faucets on and off?	_____	_____	_____	_____
8.) Get in and out of the car?	_____	_____	_____	_____

SUBJECT ASSESSMENT OF PAIN & DISEASE ACTIVITY

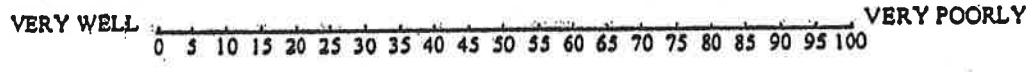
PAIN: How much pain have you had because of your arthritis? Put a mark on the scale (like this |) to show how severe your pain has been.



DISEASE ACTIVITY: Considering all the ways arthritis affects you, put a mark on the scale (like this |) to show how well you are doing.



SKIN DISEASE ACTIVITY (Psoriasis Patients Only) Put a mark on the scale (like this |) to show the activity of your SKIN DISEASE ONLY.



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Physician initials _____