Hackensack Rheumatology, LLC.

Date_____ **Patient Information**

Last Name_____ First Name _____ MI___ Date of Birth _____

Address_____City_____State_____Zip_____

Home Phone _____Cell Phone _____Work phone_____

Any Other Phone Number to reach you: _____ E-mail address: _____

SS#_____ - _____ - _____ Place of Birth_____

Race (required by Medicare/Insurance): ☐Asian ☐ Blk/Afr Amer ☐White ☐ Amer Indian ☐Pacific Isl

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino Language: _____

Occupation _____ Employer _____

Address _____

Marital Status _____Spouse's Name _____Spouse's Employer_____

# of Children_____ Emergency contact_____ Tel: _____

Lives with: Alone _____ Spouse/Partner_____ Children _____ Other _____

Referred by_____ Referring Physician _____

Physician Address/phone _____

Primary Physician_____ Address/phone _____

Other Physician _____Address/Phone _____

Pharmacy Name:_____ Pharmacy Phone:_____

Pharmacy Location:_____

OtherPharmacy/MailOrder_____

Pharmacy Location:_____

Name_____

Insurance Information:

Primary Insurance Company: _____

ID# _____ Group # _____

Name of Primary Subscriber: _____

Date of Birth _____ Relationship to Patient: _____

Secondary Insurance: _____

ID# _____ Group # _____

Name of Primary Subscriber: _____

Date of Birth _____ Relationship to Patient: _____

Tertiary Insurance: _____

ID# _____ Group # _____

Name of Primary Subscriber: _____

Date of Birth _____ Relationship to Patient: _____

Prescription: Plan _____ ID# _____

Authorization

I hereby authorize release of medical information from my patient files to my health insurance carrier(s) as needed to process my insurance claims. When my physician accepts assignment of benefits, I further authorize my insurance carriers(s) to make payment directly to my physician.

Signature: _____ Date: _____

Date_____ **Patient History**

Last Name_____First Name_____MI_____Date of Birth _____

Reason for visit/referral_____

_____

Have you had any of these Major Illnesses? Covid _____

Heart_____ Lung _____

GI _____ Kidney_____

Other Hospitalizations/illnesses_____

_____

Surgery (check off and circle)**:**

☐Knee replacement (L R) ☐Knee arthroscopy (L R) ☐Hip replacement (L R) ☐Other hip/knee _____

_____

☐Shoulder surgery (L R) _____☐Foot Surgery (L R)_____

☐Carpal tunnel (L R) ☐Trigger finger (which?_____) ☐Other hand/wrist/elbow_____

☐Cervical (neck)_____ ☐Lumbar (low back) _____

☐Abdominal surgery (gallbladder, intestines, liver)_____

☐Heart surgery: ☐Bypass_____☐Valve_____☐Angioplasty_____

☐Other chest/lung surgery _____

☐Vascular/carotid _____

☐Cataract surgery (L R) ☐Oral surgery_____☐Thyroid surgery _____

☐Other surgery _____ _____

Current **Medications** _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you/did you use: **cigarettes**_____ How many years?_____Quit date? _____

Exposure to second hand smoke?_____ Illicit Drugs? (Y N) _____

Alcohol regularly (Y N) ? How much?_____Previous use?_____Quit Date?_____

Do you feel safe at home?_____

Describe your usual **exercise** _____

Describe your usual **diet**_____

What would you change in your diet? _____

Allergies to drugs? What happens? ☐Please check if no medication allergies

☐Penicillin?_____☐Sulfa?_____☐Other antibiotics?_____

☐Antiinflammatories (Motrin,etc) _____ ☐Other medication allergies _____

☐Other allergies/sensitivities _____

Name_____ **Medical History (now and/or in the past)** **Date**_____

Rheumatoid arthritis ☐
Psoriatic arthritis ☐
Osteoarthritis ☐
☐Hands ☐Shoulders ☐Hips
☐Knees ☐Ankles ☐Feet
Carpal tunnel ☐
Pain/arthritis in the hands ☐
Pain/arthritis in the knees ☐
Pain/arthritis in other joints ☐
Swelling in the hands/wrists ☐
Gout ☐
Muscle disease ☐
Systemic lupus ☐
Vasculitis ☐

Back pain/stiffness ☐
Neck pain/stiffness ☐
Sciatica ☐
"Pinched nerve" ☐
Sleep disturbance ☐
Restless leg ☐
Fibromyalgia ☐
Chronic pain ☐

Fractures(list)

Osteopenia ☐
Osteoporosis ☐

Heart Disease ☐
Angina/chest pain ☐
Coronary artery disease ☐
Heart Murmur ☐
Atrial fibrillation ☐
High blood pressure ☐
Heart failure ☐
Leg swelling ☐
Palpitations/irregular beat ☐
Blood vessel disease ☐

Diabetes/high sugar ☐
Diabetes needing insulin ☐
High Cholesterol ☐
Thyroid disease ☐

Stroke ☐
Weakness ☐

Numbness ☐
Tingling in hands/feet ☐

Other neurological disease ☐

Headaches ☐
Migraines ☐
Hearing impairment ☐
Visual impairment ☐
Shortness of breath ☐
Lung disease ☐
Emphysema ☐
COPD ☐
Asthma ☐
Sleep apnea ☐
Frequent cough ☐
Sinusitis ☐
Tuberculosis ☐

Kidney disease ☐
Kidney stones ☐
Frequent bladder infections ☐
Sexually transmitted disease ☐
HIV/Aids ☐
Difficulty urinating ☐

Ulcer ☐
Gastrointestinal bleeding ☐
Black tarry stools ☐
Hiatus hernia/reflux ☐
Barrett's esophagus ☐
Frequent nausea ☐
Abdominal pain ☐

Change in bowel habits ☐
Constipation ☐
Colon polyps ☐
Diverticulosis ☐
Diarrhea ☐
Irritable bowel ☐

Hepatitis/jaundice ☐
Hepatitis (A B C) ☐
Liver disease ☐
Bowel inflammation ☐
Crohn's disease ☐
Ulcerative colitis ☐

Acne ☐
Skin cancer ☐

Eczema ☐
Rash (significant) ☐
Psoriasis ☐
Severe dandruff ☐
Allergies (seasonal, hay fever) ☐

Frequent fevers ☐
Chronic fatigue ☐
Unexplained weight loss ☐
Anemia ☐
Other blood disorder ☐

Blood clots/phlebitis ☐
Color change in the hands ☐
Dry mouth ☐
Dry eyes ☐
Other eye disease ☐
Sores in the mouth ☐

Anxiety ☐
Depression ☐
Attention deficit disorder ☐
Bipolar disease ☐

Cancer (list)

For women:
Polycystic ovaries ☐
Infertility ☐
Menopause age
Pap test
Mammogram
Date of last period
Number of pregnancies

For Men:
Prostate disease ☐
Prostate cancer ☐
Low testosterone ☐

Date of recent physical
Blood tests
EKG
Flu vaccine
Pneumonia vaccine

Covid vaccine

Name_____ *Hackensack Rheumatology, LLC*

Family History: Date_____

Has anyone in your family had these conditions?

Adopted _____

	Mother	Father	Brother/Sister		Son/Daughter		Other (Indicate Family Member)
Gout_____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Rheumatoid arthritis____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Osteoarthritis _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Arthritis of hands_____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
OA of Hips _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
OA of Knees _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Other osteoarthritis _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Psoriatic arthritis_____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Spine arthritis _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Lupus _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Sjögren's _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Sarcoidosis _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Scleroderma _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Muscle disease_____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Vasculitis _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Alzheimer's _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Asthma _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Cancer (type?) _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Heart Disease _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Stroke _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Hypertension _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Cholesterol _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Diabetes _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Depression _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Alcohol _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Migraines_____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Obesity _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Osteoporosis _____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Kidney disease_____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____
Thyroid disease_____	☐ M___	☐F___	☐B___	☐S___	☐S___	☐D___	☐ O _____

HACKENSACK RHEUMATOLOGY

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have received a copy of HACKENSACK RHEUMATOLOGY'S NOTICE Of PRIVACY PRACTICES.

_____ _____

Signature of Patient Date

Hackensack Rheumatology, LLC

Date _____

Patient Name:_____

Due to changes in federal law, we are asking our patients to update home, cell and work phone numbers. Please sign below to give Hackensack Rheumatology's physician and staff permission to contact you by phone regarding billing and insurance matters, as well as appointment reminders and health concerns, etc.

Patient Signature:_____

Contact information:

Phone numbers: Please check preferred phone

Home:_____ _____

Office:_____ _____

Cell:_____ _____