Sarasota Arthritis Center

Welcome to Sarasota Arthritis Center! We are delighted you have chosen our practice for your medical care. This packet **MUST** be completed and returned to book your appointment with one of our rheumatologists.

***Sarasota* Arthritis Center**
1945 Versailles St
Sarasota, Fl 34239
P - 941-365-0770
F- 941 955-8977

***Bradenton* Arthritis Center**
6020 SR 70 East, Ste 103
Bradenton, Fl 34203
P- 941 567-4021
F- 941 567-4102

***Venice* Arthritis Center**
1225 Jacaranda Blvd.
Venice, Fl 34292
P- 941 484-4409
F- 941 837-2848

***IT IS IMPORTANT TO ARRIVE AT LEAST 30 MINUTES PRIOR TO YOUR APPOINTMENT TIME.**

IF YOU ARE LATE, YOUR APPOINTMENT MAY BE CANCELLED. *

Please reference the following information to help prepare for your visit:

Have all applicable records (office notes, MRI results, lab work results, x-ray results, etc.) faxed to our New Patient Coordinators at 941-955-8977. Please note that it is the patient's responsibility to obtain these records.

- ✓ Bring a **picture ID** to your appointment.
- ✓ Bring your current **insurance card(s)** to your appointment and to each follow up appointment thereafter.
- ✓ Expect to be in our office 60-90 minutes.
- ✓ **Please keep this page. Return the rest of this *completed* packet via one of the following:**
  - Encrypted email to:
    - newpatients@arthritiscenters.net

We take great pride in our ability to provide a personalized approach to each patient. We appreciate the opportunity to participate in your rheumatologic care.

We look forward to seeing you!

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PATIENT REGISTRATION

Patient Information (please print clearly)

Patient Last Name	First Name	Middle	Date of Birth *(MM/DD/YYYY)*	Sex	SSN

Mailing Address	City	State	Zip Code
Alternate Address	**City**	**State**	**Zip Code**

Home Number	Cell Number	Alternate Number	Activate Patient Portal ☐ Yes ☐ No	Email Address

Primary Language	Do You Need an Interpreter? ☐ Yes ☐ No	Ethnicity	Hearing Impaired? ☐ Yes ☐ No	Vision Impaired? ☐ Yes ☐ No

Retired ☐ Yes ☐ No	Employer Name	Employer Address, City, State	Employer Telephone

Emergency Contact Information

Last Name	First Name	Relationship to Patient	Contact Number

Medical Insurance Policy Holder ☐ **Check Here if Uninsured**

Primary Insurance Company	Policy Holder Last Name	Policy Holder First Name

Relationship to Patient	Subscriber ID	Group Number	Date of Birth *(Month/Day/Year)*

Secondary Insurance Company	Policy Holder Last Name	Policy Holder First Name

Relationship to Patient	Subscriber ID	Group Number	Date of Birth *(Month/Day/Year)*

Responsible Party If Other Than Patient

Last Name	First Name	Relationship to Patient	Contact Number

Street Address	City	State	Zip Code

Please indicate if you have any of the following OPEN CLAIMS:

Workers Compensation: ☐ Yes ☐ No	Auto Accident: ☐ Yes ☐ No	Slip and Fall/other Liability: ☐ Yes ☐ No
If you have answered yes to any of these, please explain:		

Assignment of Benefits / Consent for Treatment

I do hereby assign all medical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I acknowledge receipt of the Financial Policy and I understand that I am responsible for all charges not paid by insurance. I authorize this practice to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, and diagnostic procedures (including but not limited to lab and radiographic studies) as ordered by attending providers.

Signature of Patient/Guardian/Legal Representative	**Date *(Month/Day/Year)***

Sarasota Arthritis Center

MEDICAL HISTORY

Patient Information (please print clearly)

Last Name	First Name	Middle Initial	Date of Birth *(Month/Day/Year)*
Reason for Visit			

Primary Care Doctor	**Preferred Pharmacy Information**
Name	Pharmacy Name
Address	Address
Phone Number	Phone Number
Group Practice Name	Specialty Pharmacy

List your current medications *-or-* provide current med list (INCLUDING any over the counter, supplements, injections, etc)

	Frequency	**Dose**		**Frequency**	**Dose**
1.		Mg	5.		Mg
2.		Mg	6.		Mg
3.		Mg	7.		Mg
4.		Mg	8.		Mg

Past Surgical History (List prior surgeries/year)

1.	**3.**
2.	**4.**

Allergies (List all allergies and reactions)

1.	**3.**
2.	**4.**

Prior Injections (List last received date)

FLU Vaccine:	**Pneumonia Vaccine:**	**COVID-19 Vaccine:**

Past Medical History (Please list any formal diagnoses & approximate year of onset)

_____

_____

Social History

Cigarette Smoking/Tobacco Use ☐ Yes ☐ No	If yes, quantity per day:	If yes, how long?	Did you quit? ☐ Yes ☐ No	What age did you quit?
Use E-Cigarettes ☐ Yes ☐ No	If yes, quantity per day:	If yes, how long?	Did you quit? ☐ Yes ☐ No	What age did you quit?
Drink alcohol? ☐ Yes ☐ No	If yes, quantity per day:	If yes, how long?	Did you quit? ☐ Yes ☐ No	What age did you quit?

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Patient Information (please print clearly)

Last Name	First Name	Middle Initial	Date of Birth *(Month/Day/Year)*

Past Medical History – Rheumatology Specific (Check formal diagnoses and give year of onset

☐ Osteoarthritis [location]	**Year**	☐Fibromyalgia	**Year**	☐ Polymyalgia Rheumatic (PMR)	**Year**
☐ Degenerative discs in cervical spine		☐ Gout		☐ Psoriasis	
☐ Osteopenia		☐ Rheumatoid Arthritis		☐ Psoriatic Arthritis	
☐ Osteoporosis		☐ Systemic Lupus Erythematosus (SLE)		☐ Ulcerative Colitis or Crohn's Disease [circle]	
☐ Fracture spine or hip [circle]		☐ Discoid Lupus		☐ Ankylosing Spondylitis	
☐ Fracture other site Specify:		☐ Systemic vasculitis [type]		☐ Other (specify)	
☐ Autoimmune liver or autoimmune thyroid disease [circle]		☐ Iritis or Uveitis or Scleritis [circle]		☐ Other (specify)	

Family History (Check if family member has CONFIRMED diagnosis and give relationship)

☐ Osteoarthritis Who: Paternal / Maternal [circle]	☐ Psoriasis Who: Paternal / Maternal [circle]	☐ Polymyalgia Rheumatica Who: Paternal / Maternal [circle]	☐ Blood clots Where: Who: Paternal / Maternal [circle]
☐ Osteoporosis Who: Paternal / Maternal [circle]	☐ Crohn's Disease Who: Paternal / Maternal [circle]	☐ Systemic Vasculitis Who: Paternal / Maternal [circle]	☐ Hypertension Who: Paternal / Maternal [circle]
☐ Gout Who: Paternal / Maternal [circle]	☐ Ulcerative Colitis Who: Paternal / Maternal [circle]	☐ Parent w/ hip/spine fracture Who: Paternal / Maternal [circle]	☐ Diabetes Who: Paternal / Maternal [circle]
☐ Rheumatoid Arthritis Who: Paternal / Maternal [circle]	☐ Ankylosing Spondylitis Who: Paternal / Maternal [circle]	☐ Cancer Who: Paternal / Maternal [circle]	☐ Heart Disease Who: Paternal / Maternal [circle]
☐ Systemic Lupus Who: Paternal / Maternal [circle]	☐ Iritis or Scleritis Who: Paternal / Maternal [circle]	☐ Tuberculosis Who: Paternal / Maternal [circle]	☐ Stroke Who: Paternal / Maternal [circle]

Sarasota Arthritis Center

MEDICAL RECORD RELEASE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Information (please print clearly)

Last Name	First Name	Middle Initial	Date of Birth *(MM/DD/YYYY)*

Street Address	City	State	Zip Code

Phone Number	

☐ **I AUTHORIZE _____ TO DISCLOSE/RELEASE THE INFORMATION BELOW TO SARASOTA ARTHRITIS CENTERS**

I hereby authorize the use and/or disclosure of my protected health information:

FROM: Name of Provider/Facility: _____

Address:_____

Phone: _____ FAX:_____

TO: Name of Provider/Facility: _____

Address:_____

Phone: _____ FAX:_____

FOR THE PURPOSE OF: ☐ Continued Medical Care ☐ Billing ☐ Personal ☐ Insurance ☐ Other:_____

THE FOLLOWING INFORMATION TO BE DISCLOSED/RELEASED:

☐ Entire Medical Record ☐ Office Notes ☐ Insurance Records

☐ Labs/Imaging/Other reports ☐ Billing Records ☐ Other:_____

*State and federal law protect the following information. This information will be released unless you indicate otherwise below (**initial**).*

____ NO Substance Use disorder records ____ NO Sexually Transmitted Disease Records

____ NO HIV/AIDS Records ____ NO Psychotherapy Notes

POSSIBILITY OF REDISCLOSURE: I understand that any information released may be subject to re-disclosure and no longer protected by state and federal regulations.

EXPIRATION AND REVOCATION: *I acknowledge that I have read this authorization and fully understand its contents. I understand that this authorization is valid until revoked in writing, but not to exceed 24 months from the date I sign it. I have the right to revoke this authorization in writing at any time.*

_____ _____

Signature of Patient or Legally Authorized Representative* Date

*If other than patient signing, then state relationship:_____

Sarasota Arthritis Center

CANCELLATION AND "NO SHOW" POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, the Sarasota Arthritis Center reserves the right to charge a fee of $50.00 for all missed appointments ("No Shows").

New Patient appointments that result in a missed appointment ("No Show") will be charged a fee of $125.00.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "No Shows" in any 12-month period may result in termination from our practice.

Kindly notify us 24-hours in advance if you are unable to keep an appointment. This allows us to provide care to other patients in need of an appointment.

Thank you for understanding and cooperation as we strive to best serve the needs of our patients.

This policy applies at all listed locations:

Sarasota Arthritis Center	***Bradenton Arthritis Center***	***Venice Arthritis Center***
1945 Versailles St	6020 State Road 70 E, Ste 103	1225 Jacaranda Blvd.
Sarasota, FL 34239	Bradenton, FL 34203	Venice, FL 34292
941-365-0770	941-567-4021	941-484-4409

By signing below, you acknowledge that you have received and understand the Cancellation and "No Show" Policy.

Printed Name of Patient/Guardian/Legal Representative	**Date of Birth *(Month/Day/Year)***
Signature of Patient/Guardian/Legal Representative	**Date Signed *(Month/Day/Year)***

Disclaimer: The request of your signature and notification of our policy is a courtesy only. It is not required to balance bill the patient.