PATIENT DEMOGRAPHICS
ALL FIELDS MUST BE FILLED OUT

DATE:_____

Patient First Name: _____ Last Name: _____ Middle Name:_____

DOB:_____ **Age**:_____ **Sex: □ Male □ Female SS#:_____Drivers License #:_____**

Address:_____**City: _____State: _____Zip: _____**

Home Phone:_____ **Cell Phone**:_____ **Other Phone:_____**

Employer Name:_____ Employer Phone: _____Occupation: _____

Employers Address: _____ City: _____ State:_____ Zip:_____

Marital Status: □ Single □ Married □ Divorced □ Widowed **Spouse's Name (**If Applicable**) _____**

Race
□ American Indian or Alaska Native □ African American □ Asian (includes Pakistan or Indian Origins) □ Caucasian □ Multiracial □ Hispanic □ Decline

Language
□ English □ Spanish □ Chinese □ Vietnamese □ Italian □ Sign Language □ Other □ Decline

Primary Care Physician:_____ Phone Number:_____

Referring Physician:_____ Phone Number:_____

Who may we than for referring you?_____

In Case of an emergency who should be notified:_____ Phone Number:_____

INSURANCE FIELDS MUST BE FILLED OUT COMPLETELY
COPIES OF INSURANCE CARDS MUST BE PROVIDED
REFERRALS MUST BE OBTAINED BY THE PATIENT FROM THEIR PRIMARY CARE PHYSICIAN

Primary Insurance:_____ **Phone Number: _____**

Policy ID Number:_____ Group Number:_____

Primary Insured:_____ Relationship:_____ DOB:_____ SSN#_____

Secondary Insurance:_____ **Phone Number: _____**

Policy ID Number:_____ Group Number:_____

Primary Insured:_____ Relationship:_____ DOB:_____ SSN#_____

Northwest Houston Arthritis Center, P.A.
Shaikh Arif Ali, M.D. Adnan Peer, M.D.

PATIENT HEALTH HISTORY

Date:_____ Patient Name:_____ Date of Birth:_____

Age:_____ Allergies:_____

FAMILY HISTORY:

□ Diabetes □ High Blood Pressure □ Stroke □ Heart Disease □ Arthritis

□ Cancer (If yes list type & family member): _____

_____

SOCIAL HISTORY

Patient Occupation:_____

Do you smoke? □ Yes □ No If so, how many a day/pack:_____

Do you consume alcohol? □ Yes □ No If so, how much per? Day_____ Week:_____ Monthly: _____

Have you used social drugs in the past? □ Yes □ No If yes, which drugs:_____

Are you currently using social drugs? If so, which drugs:_____

Please list current medications (or provide an updated list to our office) **PLEASE PRINT**

_____

_____

_____

Pharmacy Name:_____ Phone Number:_____

PAST MEDICAL HISTORY

□ Measles	□ Chicken Pox	□ Mumps	□ Skin
□ Glaucoma	□ Cataracts	□ Hypertension	□ Rheumatic Fever
□ Asthma	□ Heart Attack	□ TB/STD	□ Depression
□ Hepatitis	□ PVD/Gallstones	□ CVA/Stroke	□ Kidney Disease
□ Cancer	□ Seizures/Epilepsy	□ Thyroid Disease	□ Diabetes
□ Rheumatoid Arthritis/Gout	□ Degenerative Joint Disease		□ Migranes

Please list all surgeries and year:_____

_____

Any recent hospitalizations: □ Yes □ No Any recent labs/x-rays: □ Yes □ No Please provide copy to our office

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REVIEW OF SYMPTOMS

□ Fever
□ Excessive Weight Loss
□ Excessive Weight Gain
□ Headaches
□ Migraines
□ Double Vision
□ Sinus Troubles
□ Hay Fever / Allergies
□ Chest Pain
□ Swelling in the chest
□ Palpitations
□ Hypertension
□ Dizziness
□ Fainting Spells
□ Swelling of Ankles/Legs
□ Chronic Cough/ Hempptysis
□ Wheezing / SOB / PND
□ Sensitive to Sun
□ Back Pain
□ Weakness
□ Dryness/Redness of the Eyes
□ Alopecia
□ Tender Points in Muscles

□ Heart Burn / Abdominal Pain
□ Nausea
□ Vomiting
□ Mouth Ulcers
□ Gastric Ulcers
□ Constipation
□ Diarrhea
□ Frequent or Difficult Urination
□ Excessive Thirst
□ Blood in Urine
□ Depression / Anxiety
□ Easy Bruising
□ Joint Pain
□ Joint Stiffness
□ Joint Swelling
□ Hives
□ Skin Rash / Sores
□ Numbness
□ Excessive Fatigue
□ Muscle Weakness
□ Insomnia

Please list any other health issues that you may be experiencing that is NOT listed on the above list

_____

_____

_____

_____ _____

Patient Name (Print) **Date**

_____

Patient Signature

Northwest Houston Arthritis Center, P.A.
Shaikh Arif Ali, M.D. Adnan Peer, M.D.

PRESCRIPTION POLICY – DRUGS AND THEIR POSSIBLE SIDE EFFECTS

If you are prescribed a narcotic pain medication, sleep aid, or muscle relaxer, it is to be used on a **AS NEEDED BASIS (PRN)**

EXAMPLE: Prescription says take every 8 hours **AS NEEDED**, this means you may take medication no earlier than 8 hours apart IF NEEDED. It does **NOT** mean take every 8 hours around the clock.

If you need to take medication around the clock on a steady basis to control your pain our office may refer you to a pain management doctor for better control of your pain. If referred to pain management, our office will still treat you for your diagnosis, but not for the control of the pain.

All narcotics, sleep aids, and muscle relaxers **MUST LAST 30 DAYS** with **NO EARLY REFILL** and **NO EXCEPTIONS**. If medication due date falls on a Saturday or Sunday, we will fill it the Friday before it is due. Also these medications **CANNOT** be filled with multiple pharmacies.

If you have any questions or concerns, please feel free to as the nurse.

COX 2	GI Bleeding, Renal Problems, High Blood Pressure, MI, Edema, CAD
NSAIDS	GI Ulceration and Bleeding, HTN, CAD
SULFASALAZINE	Decreased Blood Counts, Increased LFT's Allergic Reaction
METHOTREXATE	Decreased Blood Counts, Hepatic Fibrosis, Cirrhosis, Pulmonary Infilitrate or Fibrosis, Infections
PLAQUENIL	Retinal Deposits
AZATHIOPRINE	Decreased Blood Counts, Infections, Increased LFT's
CYCLOPHOSPHAMID	Decreased Blood Counts, Malignancy, Infections, Myeloproliferative Disorders, Hemorrhagic Cystitis, Infertility
CYCLOSPORIN A	Renal Insufficiency, Anemia, Hypertension, Infections
CORTICOSTERIODS	Hypertension, High Blood Sugar, Weigh Loss, Infections
ARAVA	Diarrhea, Increased LFT's, Weight Loss, Infections
REMICAID	Infections, TB, Lymphoma, Lupus, Anaphylaxis, Vasculitis
ENBREL	Infections, TB, Lymphoma, Lupus, Anaphylaxis, Vasculitis
HUMIRA	Infections, TB, Lymphoma, Lupus, Anaphylaxis, Vasculitis
PAIN MEDS	Addiction, Drowsiness, Patients advised not to drive while taking these medications, no alcohol, or other social drugs.
(NARCOTICS)	
SLEEP MEDS	Addiction, Drowsiness, Patients advised not to drive while taking these medications, no alcohol or other social drugs.

All of these above side effects have been explained to me, and I fully understand all of the listed information. I agree to report ALL reactions, and/or possible side effects that may be related to the ingestion of any referenced medications directly to our office.

_____ _____

Patient Name (Print) **Date**

_____

Patient Signature

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits directly to **Northwest Houston Arthritis Center, Shaikh Arif Ali, M.D. / Adnan Peer, M.D.** Authorization is herby granted to release information contained in the patient's medical record to the patient's medical insurance company (or it's employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome (AIDS) and Human Immune Deficiency Virus (HIV). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to **Northwest Houston Arthritis Center, Shaikh Arif Ali, M.D**. / **Adnan Peer, M.D..** I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of **Northwest Houston Arthritis Center, Shaikh Arif Ali, M.D. / Adnan Peer**, if any.

I also understand that it is my responsibility to provide **Northwest Houston Arthritis Center, Shaikh Arif, Ali, M.D**. / **Adnan Peer, M.D.** with my most current and active insurance that is effective at the time of my visit. If I fail to provide my most current and active insurance at the time of my visit, and claims are denied and/or proper referrals or authorizations were not obtained, due to my failure to provide current insurance for my visit(s) at any time, that I am fully responsible for the charges incurred for services rendered to me by **Northwest Houston Arthritis Center, P.A., Shaikh Arif Ali, M.D. / Adnan Peer, M.D.**

I fully understand that I am fully responsible for obtaining the proper referrals/authorizations for my visits as required in my benefit package through my insurance.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____ _____ _____

Patient Name(Please Print) **Patient Signature** **Date**

FINANCIAL POLICY

Thank you for choosing us as one of your healthcare providers. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment. **WE ASK THAT YOU PLEASE INITIAL NEXT TO EACH PARAGRAPH AFTER READING, THEN SIGN AT BOTTOM STATING THAT YOU HAVE READ AND UNDERSTAND THE ENTIRE FINACIAL POLICY.** Thank You.

_____ **FOR ALL NETWORK PLANS AND MEDICARE:** We accept assignment of insurance benefits; however if the insurance carrier has not made payment within 60 days from the date of service, you may be billed for the balance. If the insurance company does render payment, we will gladly refund the difference to you. Please be aware that not all services provided may be covered by your plan. It is **your responsibility** to know your benefit plan. **All co-pays and unpaid balances must be paid before the patient sees the physician.**

_____ **PATIENTS WITH HMO/POS PLANS REQUIRING REFERRAL FROM PCP:** It is the responsibility of the patient to obtain authorization or written and/or verbal referral, whichever is required by the insurance carrier, prior to the visit to our clinic. Dr. Ali is a specialist and our office does not call to obtain referrals. If a patient presents to our office without a referral, the patient must reschedule an appointment for a later date.

_____ **RETURNED CHECKS:** There will be a $30 return check fee added to the balance owed on your account for any returned checks,

_____ **ADULT PATIENTS:** Adult patients are responsible for full payment at the time of service.

_____ **MINOR PATIENTS**: The adult accompanying a minor is responsible for full payment. For unaccompanied (by parent or guardian) minors, treatment will be denied.

_____ **MISSED APPOINTMENTS:** Please help us serve our patients better by adhering to the policy of canceling appointments 244 hours in advance. Unless cancelled at least 24 hours in advance, our policy is to change for missed appointment at the rate of a normal office visit.

_____ **DOCUMENTATION FEES:** A fee will be charged for all documentation that must be completed (e.g. letters of medical necessity, FMLA, disability, dictated letters, etc.). The amount charged will depend on the specific requirements of the request.

APPROVED HIPAA CONTACTS

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **Patient** or **Legal Guardian**. If you would like to add addition contacts (other than the patient or legal guardian) that **Northwest Houston Arthritis Center** allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that request for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

_____ _____ _____

Contact Name (Please Print) Relationship to Patient Contact Phone Number

□ **Billing Account Information** □ **Medical Condition Information** □ **Emergency Contact**

_____ _____ _____

Contact Name (Please Print) Relationship to Patient Contact Phone Number

□ **Billing Account Information** □ **Medical Condition Information** □ **Emergency Contact**

My preferred method of communication regarding my **medical conditions** is indicated below **(check one)**

□ Home Phone □ Work Phone □ Cell Phone □ Mailed Letter □ Guardian

If the above method of communication is by phone, please check the appropriate box below **(check one)**

□ Leave a message with detailed information □ Leave a message with a call-back number only

CONSENT TO TREAT

I hereby authorize employees and agents of **Northwest Houston Arthritis Center, PA,** (including physician assistants and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. I also allow **Northwest Houston Arthritis Center** to provide other medical professionals, diagnostic facilities, hospital (in or out patient) and any other medical source with my personal demographics for the purpose of referring me for continued medical treatment. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____ _____ _____

Patient Name **Patient Signature** **Date**

ACKNOWLEDGEMENT OF THE RECEIPT OF NORTHWEST HOUSTON ARTHRITIS CENTER, PA NOTICE OF HEALTH INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Northwest Houston Arthritis Center, PA is furnishing you with the attached notice, which provides information about how **Northwest Houston Arthritis Center, PA** and it's physicians may use and/or disclose protected health information about you for treatment, payment, health care operation and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of the **Northwest Houston Arthritis Center**, **PA's** Notice of Health Information Practices (or had the opportunity to read if I chose).

_____ _____ _____

Patient Name (Please Print) **Patient Signature** **Date**