Notice to Patients

Your appointment is scheduled on _____ at_____.

Please note: Payment is due at time of service

Things you will need at the time of your appointment

- All current insurance cards
- Driver's License
- Completed New Patient Packet
  - Must be completed in **BLACK** pen
  - Bring completed packet to appointment, receptionist will ask for it when you check in.
  - If not filled out, must arrive 45 minutes prior to appt time to complete packet. ***Not doing this could result in your appointment being rescheduled.***
- All medical records that would pertain to the reason why you are being seen

Your first appointment usually lasts about an hour. At this appointment, your health history will be discussed in detail as well as the reason for the visit. There will also be a physical exam. Lab work and diagnostic imaging may be ordered at this time.

The second visit generally consists of a scanning ultrasound to aid in the diagnostic process.

The third visit is a comprehensive appointment. All available records, labs work, x-rays, scanning images, etc. will be reviewed and discussed, as well as available treatment plan options.

Please plan to arrive 30 minutes early for your appointment.

We look forward to seeing you.

NOTE: Please be aware that we are not a pain management clinic. We do not guarantee pain medications. To learn more about this, you may visit our website at https://managearthritis.net

Arthritis Specialty Center

Ananda Walaliyadda, MD, FACR, CCD, RMSK, RhMSUS

Diplomate of The American Board of Rheumatology

Pocatello Office
1448 East Center Street, STE E
Pocatello, Idaho 83201

Rigby Office
711 Rigby Lake Drive, STE 1400
Rigby, Idaho 83442

Ph: 208-234-1300 Fax: 208-234-1333
Website: http://managearthritis.net

Last Name _____First Name _____Middle Initial _____

Date of Birth_____ Age _____Birth Place _____Social Security # _____

Address_____City_____State_____ZIP_____

Home Phone # _____Cell Phone #_____

Email Address_____

Employer_____ Work Phone #_____

Emergency Contact Name_____ Relationship_____Phone#_____

MARITAL STATUS: Single / Separated / Married / Life Partner / Divorced / Widowed

Race (please circle one) American Indian / Asian / African American / White (Caucasian) / Hispanic / Latino / Other

Preferred Language _____

Referring Physician_____

Primary Care Physician_____

Preferred Pharmacy_____

Do you have an Advanced Directive (Living Will) ? no _____ yes _____

INSURANCE INFORMATION:

Primary Insurance_____ Policy Holders Name _____

Policy Holders Date Of Birth_____Sex_____Employer_____

Policy#_____Group#_____

Secondary Insurance_____ Policy Holders Name_____

Policy Holders Date Of Birth_____ Sex_____ Employer_____

If there is any change in your personal information (ie. Marriage, divorce, change in address or phone number, etc.) you are responsible for notifying our office immediately **in writing** to update your records. Thank you.

Signature:_____ Date:_____

Arthritis Specialty Center

CURRENT MEDICATIONS/VITAMINS/SUPPLIMENTS: (Use separate paper if needed)

Name of Medication	Dose/strength and quantity taken per day	How long taking medication	Has this helped? Please specify a lot, some, not at all

PAST TRIED AND FAILED MEDICATIONS (please circle all that apply):

Medication	Did this help?	Medication	Did this help?
Motrin/Ibuprofen		Humira (adalimumab) -Self Inject	
Celebrex/celoxib		Enbrel (etanercept) – Self Inject	
Mobic/Meloxicam		Simponi/SimponiAria (golimumab) – Self Inject / Infusion	
Aleve/Naproxen		Cimzia (certolizumab pegol) – Self inject / Provider Inject	
Indomethacin		Orencia (abatacept) – Self Inject / Infusion	
Tylenol/Acetaminophen		Actemra (tocilizumab) – Self Inject / Infusion	
Prednisone/Steroids		Remicade (infliximab) – Infusion	
Methotrexate/Rheumtrex		Rituxan (rituximab) – Infusion	
Sulfasalazine/Azulfidine		Benlysta (belimumab) – Infusion	
Arava/leflunomide		Gabapentin/Neurontin	
Imuran/Azathioprine			
Plaquenil/Hydroxychlorquine			
Colcrys/Cholchicine		Hyalgan / Synvisc (joint injections)	
Allopurinol		Kenalog / Depo-medrol (joint injections)	
Uloric			
Probenecid			

Signature:_____ Date:_____

Arthritis Specialty Center

MEDICAL HISTORY (please circle all that apply):

Cancer (type) _____ When diagnosed: _____

Psychiatric Problems (type) _____ Heart Problems (type): _____

Fractures _____

Hyperthyroidism	Hypothyroidism	Hyperparathyroidism	High Blood Pressure
Cataracts	Diabetes	Headaches/Migraines	Arthritis-unknown type
Glaucoma	Anemia	Emphysema	Rheumatic Fever
Pneumonia	Tuberculosis	Stomach Ulcers	Rheumatoid Arthritis
HIV/AIDS	Asthma	Stroke	Ankylosing Spondylitis
Iritis	Gout	Psoriasis	Psoriatic Arthritis
Jaundice	Epilepsy	Lupus	Childhood Arthritis
Crohn's Disease	Scleroderma	Sjogren's Disease	Fibromyalgia
Goiter	Osteopenia	Osteoporosis	Osteoarthritis
Kidney Disease	Colitis	Depression	Hepatitis

Other _____

Natural or Alternative Therapies used (chiropractor, magnets, massage, acupuncture, meditation): _____

_____

ALLERGIES/INTOLERANCES:

Medication/Other	Type of Reaction

SURGICAL HISTORY:

Month/Year	Type of Surgery	Reason for Surgery

HOSPITILIZATIONS: Within the last year

Month/Year	Reason (include ER visits and admissions)

Signature: _____ Date: _____

Arthritis Specialty Center

FAMILY HISTORY: (grandparents, parents, siblings, children)

Cancer (type) _____ Psychiatric Problems (type) _____

Heart Problems (type):_____ Fractures(Hip/Wrist)_____

Hyperthyroidism	Hypothyroidism	Hyperparathyroidism	High Blood Pressure
Cataracts	Diabetes	Headaches/Migraines	Arthritis-unknown type
Glaucoma	Anemia	Emphysema	Rheumatic Fever
Pneumonia	Tuberculosis	Stomach Ulcers	Rheumatoid Arthritis
HIV/AIDS	Asthma	Stroke	Ankylosing Spondylitis
Iritis	Gout	Psoriasis	Psoriatic Arthritis
Jaundice	Epilepsy	Lupus	Childhood Arthritis
Crohn's Disease	Scleroderma	Sjogren's Disease	Fibromyalgia
Goiter	Osteopenia	Osteoporosis	Osteoarthritis
Kidney Disease	Colitis	Depression	

Other _____

SOCIAL HYSTORY:

EDUCATION (circle highest level attended): High School 9 10 11 12 College 1 2 3 4 Grad School_____

Occupation: _____ Number of hours worked/per week (average): _____

Do you smoke? yes / no / sometimes Are you interested in quitting? _____
Do you chew tobacco? yes / no / sometimes
Do you exercise? yes / no / sometimes
Do you sleep well at night? yes / no / sometimes
Do you wake up feeling rested? yes / no / sometimes
Do you drink caffeinated beverages? yes / no / sometimes If yes, how much per day? _____
Do you drink alcohol? yes / no / sometimes If yes, what kind? _____ How often? _____
Do you use drugs for reasons other than medical? yes / no / sometimes If yes, please explain_____

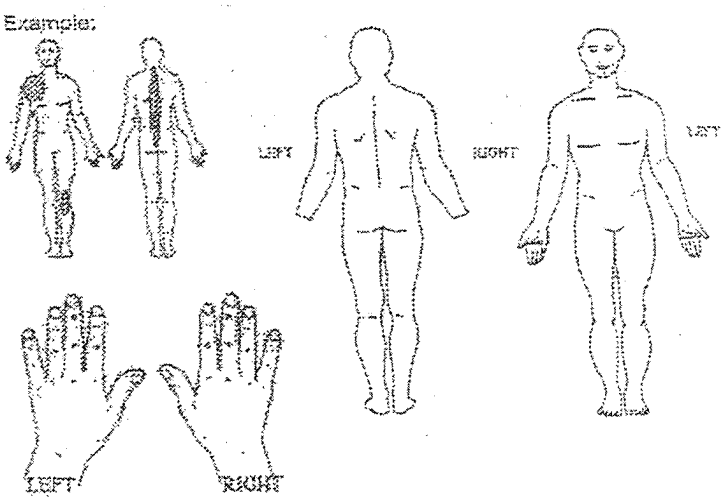
Please shade the areas where you experience pain

Briefly describe your present symptoms: _____
_____
_____

Date (approximate) symptoms began: _____

List any treatment for the symptoms
(physical therapy, surgery, injections): _____
_____

List any other practitioners you have seen for this problem:
_____



Signature:_____ Date:_____

Arthritis Specialty Center

Multi-Dimensional Health Assessment Questionnaire

Please place a check (✓) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Left Fingers	☐ 0	☐ 1	☐ 2	☐ 3	Right Fingers	☐ 0	☐ 1	☐ 2	☐ 3
Left Wrist	☐ 0	☐ 1	☐ 2	☐ 3	Right Wrist	☐ 0	☐ 1	☐ 2	☐ 3
Left Elbow	☐ 0	☐ 1	☐ 2	☐ 3	Right Elbow	☐ 0	☐ 1	☐ 2	☐ 3
Left Shoulder	☐ 0	☐ 1	☐ 2	☐ 3	Right Shoulder	☐ 0	☐ 1	☐ 2	☐ 3
Left Hip	☐ 0	☐ 1	☐ 2	☐ 3	Right Hip	☐ 0	☐ 1	☐ 2	☐ 3
Left Knee	☐ 0	☐ 1	☐ 2	☐ 3	Right Knee	☐ 0	☐ 1	☐ 2	☐ 3
Left Ankle	☐ 0	☐ 1	☐ 2	☐ 3	Right Ankle	☐ 0	☐ 1	☐ 2	☐ 3
Left Toes	☐ 0	☐ 1	☐ 2	☐ 3	Right Toes	☐ 0	☐ 1	☐ 2	☐ 3
Neck	☐ 0	☐ 1	☐ 2	☐ 3	Back	☐ 0	☐ 1	☐ 2	☐ 3

FOR OFFICE USE ONLY

1. Kiosk Data (0-10):

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

2. **PN** (0-10):

3. **PTGL** (0-10):

RAPID 3 (0-30)

Cat:

HS = >12

MS = 6.1-12

LS = 3.1-6

R= ≤ 3

***** Our office uses an automated system to remind you of your upcoming appointments and to also contact you in regards to your account and health information. *****

Preferred number to call for appointment reminders: ☐ Home ☐ Cell ☐ Work

Would you also like to receive a text message reminder? ☐ Yes ☐ No

Do you authorize personal health information to be left via voicemail or text? ☐ Yes ☐ No

Please provide the best phone number to receive direct communications via our office _____

☐ **I authorize Arthritis Specialty Center to send me calls and/or texts for my upcoming appointments and to communicate about information on my account and my health information.**

OFFICE USE ONLY

☐ Advance Directive (≥65) NO____ YES____
☐ RA MIPS Assessment (once a calendar year)
Low / Mod / Sev Poor / Good No Glucocorticoid / <10mg / >10mg (performed)
☐ FALL Risk Assessment (once a calendar year) (≥ 65)
Falls in the last year _____ Did injury occur? NO ____YES ____
☐ Medication reconciliation
☐ PAIN in vitals – if pain is ≥ 1, additional charting needed
☐ Height/Weight in vitals – If abnormal BMI, additional charting needed
(BMI Normal Range ≥18.5 to <25 kg/m2)
☐ Tuberculosis Monitoring – If on TNF, additional charting needed

Provider Orders:_____

_____

BP	HR	TEMP	O2	WT	HT

Signature:_____ Date:_____

Arthritis Specialty Center

Credit Card Authorization Form

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other
Cardholder Name (as shown on card):_____
Card Number:_____
Expiration Date (mm/yy):_____
Cardholder ZIP Code (from credit card billing address:_____

I, _____, authorize Arthritis Specialty Center to charge my credit card for any missed appointments or appointments not cancelled 24 hours prior to my visit. I understand that my information will be saved on file and only ran if I do not comply to the terms presented in the financial policy.

_____ _____

Patient Signature Date

Signature:_____ Date:_____

Arthritis Specialty Center **Ananda Walaliyadda, MD, FACR, CCD**

AUTHORIZATION FOR DISCLOSURE OF PATIENT INFORMATION

Date of Request: _____

Patient's Name: _____ Date of Birth: _____ * LAST 4 SSN_____

Address: _____ City/State/Zip _____

I authorize Arthritis Specialty Center to **RELEASE** or **OBTAIN** information from the following family members, individuals, or health care providers:

Please provide FIRST and LAST name:

1. Name _____ Phone _____ City_____
2. Name _____ Phone _____ City_____
3. Name _____ Phone _____ City_____
4. Name _____ Phone _____ City_____
5. Name _____ Phone _____ City_____
6. Name _____ Phone _____ City_____
7. Name _____ Phone _____ City_____
8. Name _____ Phone _____ City_____

***AUTHORIZATION VALID FOR:**

This request **and** any **future requests** until I am no longer a patient at Arthritis Specialty Center or I have revoked this request in writing. _____ (initials).

I understand that:

- My right to healthcare treatment is not conditioned on this authorization
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- **The first copy of your records will be provided free of charge. A charge will be applied for each additional copy.**

Signature of patient: _____ Date: _____

*YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT *

1448 East Center Street, Ste E
Pocatello, ID 83201
Tel (208) 234-1300
Fax (208) 234-1333

711 Rigby Lake Drive, Ste 114
Rigby, ID 83442
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Fax (208) 234-1333