Arthritis & Osteoporosis Treatment Center

Meera R. Oza, M.D., FACR
Diplomate of American Board of Rheumatology
Diplomate of American Board of Internal Medicine
Douglas W. Roane, M.D., FACR
Diplomate of American Board of Rheumatology

2100 Kingsley Ave., Orange Park, FL 32073, Phone: (904) 276 - 0001, Fax: (904) 276 – 5333

Dear patient,

Welcome to our practice!

At our office we are committed to our patients. Our mission is to meet or exceed your expectations from your provider, our clinical staff will ensure your quality of care and, our billing staff will give you peace of mind in making sure that all your claims are billed correctly.

Attached are the forms that you need to fill out before coming to our office.

Please give us a call two days prior to your appointment to verify insurance information.

Remember to call your insurance company and double check if we do participate with your insurance. Also do not forget to bring your referral if required by your insurance. Patient will be responsible for any charges not covered by your insurance. All copays, co insurance and deductibles will be collected up front.

Please make sure you bring the following:

1. ***All enclosed pages, please fill in all requested information.***
2. ***All insurance cards.***
3. ***A list of all current medications you are taking, with the prescribing doctor's name(s).***
4. ***A copy of all blood work you have had done recently (within the last year). If you prefer you may have your doctor fax results to our office at (904) 276-5333.***
5. ***All x-rays within the last year.***
6. ***Reports of all other diagnostic tests you have had done within the last year, which is pertinent to your visit with us. (MRI, Bone Scan, Bone Density Test, etc.)***

Failure to bring this may result in having to reschedule your appointment.

Please note:
Dr. Oza suffers from severe allergies. Please do not wear any scented perfume, cologne, aftershave, body spray, lotion, etc. Thank you for your consideration.

If you have any questions or need directions to our facility, please call us at (904) 276-0001.

Thank you.
Arthritis and Osteoporosis Treatment Center

PATIENT REGISTRATION

Patient's Last Name: _____First Name: _____ M.I: _____

Home-Ph. #: (_____) _____ Work Ph: (_____) _____ D.O.B. _____

Cell Phone #: (_____) _____ Email address:_____

Address: _____ City:_____State/Zip:_____

SS # : _____ - ____- _____ Race: _____ Ethnicity: _____ Language: _____

Sex : M /F Marital Status: M S D W

Employer/School :_____Occupation:_____

Policy Holder's Last Name:_____First Name:_____M.I._____

SS #: :_____ -_____ - _____ D.O.B._____Relationship to Patient: _____

Referring Physician:_____Phone #: (_____) _____ _____

Referring Pysician address: _____

Primary Care Physician: _____ Phone #: (_____)

_____ _____

Emergency Contact: _____ P hone #:(_____)-_____-_____

Relationship to Pt._____

Primary Insurance: _____I D # :_____ Policy Holder : _____

Secondary Insurance: _____ID # :_____ Policy Holder : _____

How did you hear about us? __ Yellow pages __ Friend __Website __ Magazine __ Radio __ Family doctor __ Referring physician __ Internet search (which site?_____)

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and family physician and to my insurance company, if applicable.
I allow fax transmittal of my medical records if necessary.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Arthritis & Osteoporosis Treatment Center should they elect to receive such payment.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization
.

Patient Signature:_____ Date:_____

Note: Medicare Part B may require a separate signature authorizing release of information to the Health Care Financing Administration and Social Security Administration.

PATIENT NAME:_____**DOB**_____**DATE:**_____

PATIENT HISTORY:

OCCUPATION: _____Number of hours worked/average per week? _____
The name of the physician providing your GENERAL medical care? _____

BRIEFLY DESCRIBE THE REASON FOR THIS VISIT:_____
_____
_____
Date symptoms began (approximately) _____. Diagnosis given? (Please list) _____
_____
Previous treatment for this problem (include physical therapy, surgery or injections: **medications to be listed later)**.
_____
_____
Please list the names of other practitioners you have seen for this problem: _____
_____

IF YOU HAVE PAIN, PLEASE DESCRIBE BELOW:

LOCATION: __ all over __hands __wrists __elbows __shoulders

__neck __back __hips __knees __ankles __feet

DESCRIBE YOUR PAIN: __dull __achey __sharp __stabbing

__pins and needles __burning __constant __intermittent

SEVERITY OF PAIN: (Circle a number for severity of pain on a scale of 1-10)

0 1 2 3 4 5 6 7 8 9 10

DURATION OF PAIN: (Fill in for how long ago your pain appeared for the first time)

____days ____weeks ____months ____years ____other

TIMING: (Mark when your pain is the worst)

__ Morning __ Afternoon __ Evening __ Nighttime

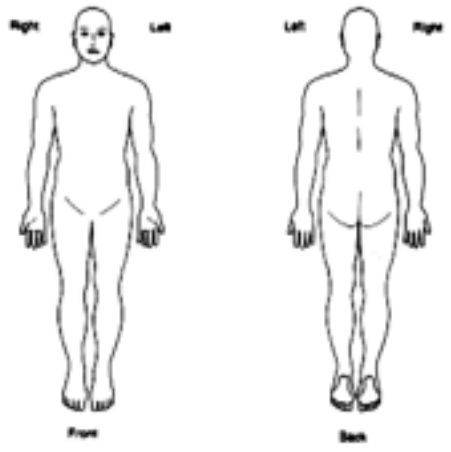
WHAT MAKES YOUR PAIN WORSE: Pain increases with: ___ activity ___rest

WHAT MAKES YOUR PAIN BETTER: __ Ice __ Heat __ Don't know/doesn't apply

WHAT MAKES YOUR PAIN WORSE: __Sneezing __ Coughing __ Walking __ Standing

__ Sitting __ Don't know/doesn't apply

ON THE DIAGRAM, PLEASE MARK THE LOCATION OF YOUR PAIN:



(OFFICE USE ONLY)

_____
Reviewed by Date

PATIENT NAME:______________________________DOB_____________DATE:______________

DRUG ALLERGIES: NO___ YES___

Medication:	**Type of Reaction:**

CURRENT MEDICATIONS: (list any medication you are taking at this time. Include such items as aspirin, vitamins, laxatives, calcium supplements, etc.)

Name of drug	**Purpose**	**Dose** (include strength & number of times per day)	**How long** have you taken this medication?	**Please check: Helped?** A lot	Some	Not at all

PATIENT'S PREFERRED PHARMACY INFORMATION:

Pharmacy name: ____

Pharmacy address: ____

Pharmacy phone number: _________________________________

Pharmacy fax number: ___________________________________

Mail order pharmacy phone #: ____________________________

Mail order pharmacy electronic Id #: ________________________

Mail order pharmacy fax #: _______________________________

Mail order pharmacy name and address: ____

PATIENT NAME:_____**DOB**_____**DATE:**_____

PAST MEDICAL HISTORY: At any time have you had any of the following (PLEASE ***circle*** either (Y)es or (N)o for each symptom).

Y / N Hepatitis **Y / N** Diabetes **Y / N** High blood press __ Joint Replacement Surg _____ Year_____

Y / N T.B. **Y / N** Thyroid **Y / N** Peptic ulcer __ Arthroscopic Surg_____ Year_____

Y / N Cancer **Y / N** Fracture **Y / N** Heart disease __ Spine Surg _____ Year_____

__ Coronary bypass_____ Year ____

Menopause yr _____ __ Complete hysterectomy __ Partial hysterectomy

Other medical problems_____

Other surgeries _____
_____

FAMILY HISTORY: (PLEASE ***circle*** either (Y)es or (N)o for each symptom). If applicable, please indicate your relationship to the person with each condition.

Y / N Rheumatoid arthritis_____ ***Y / N*** Lupus or "SLE"_____

Y / N Osteoarthritis _____ ***Y / N*** Heart Disease _____

Y / N Cancer _____ ***Y / N*** Tuberculosis _____

Y / N Osteoarthritis_____ ***Y / N*** Ankylosing Spondylitis_____

Y / N Psoriasis _____ ***Y / N*** Gout_____

Y / N Diabetes_____ ***Y/N*** Hypertension _____

Other arthritis conditions: _____

What health conditions does your mother have? _____ deceased? Y / N

What health conditions does your father have? _____ deceased? Y / N

SOCIAL HISTORY: (Please circle Yes or No) WHAT KIND HOW MUCH HOW LONG

Y **N** Do you or have you used tobacco products? _____ _____ _____

Y **N** Do you consume alcohol? (Please circle answers below)
Wine Beer Spirits
Rarely **a few days a week** **most days**
On the days I have alcohol, I usually have: One glass, two, three, four or more.

Y **N** Do you use recreational drugs? _____ _____ _____

Marital status __ Single __ Married __ Divorced __ Widowed

VACCINATIONS:

Y / N Flu shot - when? _____ **Y / N** Pneumonia shot - when? _____ **Y / N** Shingles vaccine - when? _____

(OFFICE USE ONLY) Reviewed by: _____ Date:_____

PATIENT NAME:_____**DOB**_____**DATE:**_____

REVIEW OF SYSTEMS: **(*NOTE: ALL UNMARKED ITEMS INDICATE A NEGATIVE RESPONSE)**

Please check each symptom as it pertains to you.

CONSTITUTIONAL:
__ Recent weight loss/amount
__ Fatigue
__ Fatigue
_ Chills_
__ Fever

NERVOUS SYSTEM:
__ Headaches
__ Dizziness
__ Numbness
__ Tremors
__ Seizure disorder
__ Others
_____

ALLERGY/IMMUNOLOGY:
__ Hay fever
__ Drug allergy
_____
__ Other
_____

EARS/NOSE/THROAT
__ Sudden loss of hearing
__ Ear infection
__ Sinus problems
__Dry mouth
__Sore Throat_
__Other _____

EYES:
__Blurred vision
__Double vision
__Dry eyes
__Eye pain
__Other _____

ENDOCRINE:
__ Excessive thirst
__ Too hot/cold
__Tired/sluggish
__Other

HEMATOLOGIC/LYMPH:
__ Anemia
__ Blood clotting problem
__ Swollen glands
__Other _____

CARDIOVASCULAR:
__ Chest pain
__ Swelling legs or feet
__Varicose veins
__High blood pressure
__Heart murmur
__Other _____

RESPIRATORY:
__ Shortness of breath
__ Frequent cough
__Night sweats
__ Snoring

GASTROINTESTINAL:
__ Nausea/vomiting
__ Stomach pain
__ Heartburn
__ Persistent diarrhea

GENITOURINARY:
__ Pain or burning urination
__ Urinary frequency
__Urinary retention
__ Discharge from penis or vagina
__ Genital sores/ulcers
_Other
_____

RHEUMATOLOGIC
__Sun sensitive rash
__Red eyes/scleritis/ conjunctivitis
__Difficulty swallowing
__Frequent sores in mouth
__ Color changes in hands or feet with cold

OB/GYN (if applies)
__Last menstrual period _____
__ # pregnancies _____
_# live births _____
__ # children _____

-

SKIN:
__ Skin rash
__ Boils
__ Persistent itching
__ Recent hair loss
__Other
_____

PSYCHIATRIC:
__Depression
__Anxiety
__Mood swings

__ Morning stiffness
Lasting how long?
__ Minutes
__ Hours
__ Joint pain
__ Balance Problems
__ Muscle weakness
__ Joint swelling

PSYCHIATRIC:

__ Depression
__ Anxiety
__ Mood swings

Date of last eye exam: _____
Date of last chest x-ray: _____
Date of last tuberculosis test: _____

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Permission to discuss Medical Case

Date: _____

Patient name: _____
Date of Birth: _____

I hereby give permission to Meera R. Oza M.D. or Douglas Roane, M.D. and staff to discuss my medical case and personal information with the following individuals:

{Please list **names** and **relationship** to you.}

1. _____ Relationship to patient: _____ phone #: _____
2. _____ Relationship to patient: _____ phone #: _____
3. _____ Relationship to patient: _____ phone #: _____
4. _____ Relationship to patient: _____ phone #: _____

I understand that the above mentioned individuals may speak to Dr. Oza, Dr. Roane or staff about anything concerning my medical condition. The above also has my permission to sign for any prescriptions, x-rays or medical records that may need to be picked up from the office for me in the future.

I also authorized Arthritis and Osteoporosis Treatment Center to leave a message in my answering machine regarding my treatment, blood work results, appointments and, billing issues.

I understand that if in the future I wish to revoke my permission, I **must** notify this office in writing.

_____ _____
Patient's signature Date:

_____ _____
Witness Signature

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Statement of Policies

The following policies are laid down for mutual convenience and benefit, please read them carefully and sign at the bottom to indicate your agreement with it.

*We strictly provide **Rheumatological services**; we **do not** provide primary care services. Patients are expected to have or arrange for a primary care physician.*

*We **do not** do evaluation or paper work for **disability**.*

*We **do not** provide medication refills on the **weekends.***

***Deductible** and **co-pay** associated with each visit are payable at the beginning of that visit. Any outstanding balance at the beginning of the visit is also fully payable at the time of your visit. **A $25 billing fee will be added to any unpaid co-pays, co-insurance, deductibles or balance.** If you are not able to pay, please make special payment arrangements with our business office at the beginning of the visit.*

Patient is responsible for referrals required by their insurance, also is responsible to call their insurance company to make sure Dr. Meera Oza or Dr. Douglas Roane is a participating provider for their insurance. Patient will be responsible for any charges not covered by your insurance.

*If you are not able to keep your appointment for the medical visit, please call during office hours to cancel your appointment at least **48 hours in advance**. Failure to do so will result in a **$50.00** (fifty dollars) **charge for a broken appointment.***

***Dr. Oza is allergic to perfumes and other odors.** Please avoid wearing perfumes or anything with a strong smell during your visit.*

*During the first visit, the patients may be seen by any of the **nurse practitioners or the physician assistant** in order to obtain initial information, and then will be seen by the doctor.*

*During the follow-up visits, the patient **may be seen** by any of the nurse practitioners or the physician assistant who work under the close supervision of a physician. The physician will see the patient if the nurse practioner or the physician assistant feel the need to do so.*

*I acknowledge that I have read and understood the **Statement of Policies** carefully, and agree to abide by them.*

*Patient's Signature:*_____ *Date:*_____

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CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the practice lobby. The notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register for treatment or health care services we may offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the practice Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the Privacy Official at (904) 276-0001. You will not be penalized for the filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By signing below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Patient Name (print) *Patient Signature*

_____ _____
Date *Chart Number*