CENTER FOR ARTHRITIS & OSTEOPOROSIS
3100 Princeton Pike, Building 4, Suite D, Lawrenceville, NJ 08648
○ Humaira Adenwalla, MD

PATIENT INFORMATION:

Name:_____ Date of Birth:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Home Ph: (_____)_____ Cell Ph:_____ Work Ph:_____
Email (Required)_____
SSN:_____ Marital Status: Sex: ○ M ○ F
Weight: Height: Level of Pain (1-10):
Primary Care Physician: _____ Phone:_____
Emergency Contact Name:) _____ Relationship:_____
Home Ph: (_____ _____ Cell Ph: _____
Pharmacy Name:_____ Phone: _____ _____

ACCOUNT INFORMATION:

Responsible Party: ○ Self ○ Spouse ○ Parent ○ Other
Guarantor (if other than self):_____ Relationship:_____
Address (if different from above): _____ Home Ph: (_____)
_____ Cell Ph:_____ Work Ph:_____

INSURANCE INFORMATION:

Insurance Company: _____
Subscriber:_____ Relationship:_____
Date of Birth:_____ SSN:_____ Sex: ○ M ○ F
Address:_____
Home Ph: (_____)_____ Cell Ph:_____ Work Ph:_____

ADDITIONAL INFORMATION:

Preferred Language:_____ Ethnicity:_____ Race: _____
Ethnicity Options: Hisponic/Latino, Non-Hispanic/Non-Latino, Not Reported, Declined
Race Options: White, African American, Asian, Native Hawaiian/Pasific Islander, American Indian/Alaska Native, Multiple Races, Not Reported, Declined

ASSIGNMENT OF BENEFIT AND RELEASE OF INFORMATION:

I certify that the information provided herein is correct and accurate and hereby authorize the center for arthritis and Osteoporosis PC to submit claims to Medicare, Medicaid and commercial prayers on my behalf. I assign any payment and/or benefit from these payers for the services to process. I further authorize the release of any medical record necessary for the adjudication and payment of these claims or any authorizations for services or procedures rendered or to be rendered. I understand balances for deductibles, coinsurance, copayments and non-covered services are my financial responsibility. If any balances become delinquent and are referred for further collection activity, I may become liable for any cost of collection including collection fees, court filings and legal fees.

_____

Signature Date

Name:_____DOB:_____○ M ○ F

Reason for Today's Visit:

Present Medications:

Past Medical History:
(Briefly list unusual CHILDHOOD diseases, MAJOR SURGERY, and MAJOR ILLNESS, other than your current complaint.)

Family History: (indicate any major medical conditions that run in your family, especially a history of Gout or Psoriasis)

Allergies to Medications?

Social History:
Occupation:_____

Children (how many): _____

Do you smoke?_____HowLong?_____

Do you drink alcohol?_____

How much?_____

Condition:	Y	N	Condition:	Y	N
Skin rash or Psoriasis	☐	☐	Recurrent chest pain	☐	☐
Pilling or infection of nails	☐	☐	Pleurisy	☐	☐
Hardening or lightening of skin	☐	☐	Asthma or bronchitis	☐	☐
Recent of Unexplained hair loss	☐	☐	Recurrent cough or vomiting of blood	☐	☐
Recurrent sores on/in penis or vagina	☐	☐	Recent nausea or vomiting	☐	☐
Frequent or recurring mouth sores	☐	☐	Stomach ulcer or intestinal trouble	☐	☐
Recurrent conjunctivitis or pink eye	☐	☐	Stomach pain or heartburn	☐	☐
Iritis, Uveitis or red eye	☐	☐	Hemorrhoids or colitis	☐	☐
Anemia or blood disease	☐	☐	Frequent loose bowel movements	☐	☐
Severe bleeding problems	☐	☐	Hepatitis, liver trouble or jaundice	☐	☐
Frequent headaches	☐	☐	Kidney or bladder disorder	☐	☐
New excessive fatigue	☐	☐	Psychiatric or psychological treatment	☐	☐
Emotional or nervous problems	☐	☐	Epilepsy, fits or convulsions	☐	☐
Depression	☐	☐	History of recurrent cancer or tumors	☐	☐
Recent progress or recurrent back pain other than the occasional lower back ache?				☐	☐
Inability to produce normal amounts of saliva?				☐	☐
Difficulty in making tears, dryness or gritty feeling of the eyes on awakening?				☐	☐
On exposure to sunlight, do you become ill, develop aching joints or severe skin rash?				☐	☐
Have you experienced a miscarriage?				☐	☐
If so how many Raynaud's Syndrome (hands turn blue on exposure to the cold)?				☐	☐
Have you been bitten by or removed any ticks?				☐	☐
Inflammation of your veins or blood clots?				☐	☐
Is there any compensation claim pending as a result of an injury or accident?				☐	☐
Have you recently been out of the United States?				☐	☐
Have you been seen by a Rheumatologist before?				☐	☐
If so, Name:			Phone:		

CENTER FOR ARTHRITIS & OSTEOPOROSIS
3100 Princeton Pike, Building 4, Suite D, Lawrenceville, NJ 08648

Initials OFFICE POLICIES:

_____ I understand that if I fail to cancel my appointment within 24 hours of my scheduled time, I will be charged a $50.00 fee. I understand that Medicare and other commercial insurance companies will not reimburse me for this fee. By signing I am agreeing to these terms.

_____ I understand that if my check is returned, there will be a $35 charge in addition to the money owed.

_____ I understand that it is my responsibility to pay any co-pays, co-insurance and deductibles at the time of service.

_____ I understand that it is my responsibility, if required by my insurance, to bring a valid referral with me at the time of service. If I do not, I understand that the insurance company may not pay the **Center for Arthritis & Osteoporosis** and therefore I will be fully responsible for the cost of my visit. By signing I am agreeing to these terms.

_____ I understand that the **Center for Arthritis & Osteoporosis** will make every effort to explain the cost of visits, medication and procedures but it is my responsibility to be aware of my insurance companies reimbursement policies and guidelines. I understand and acknowledge that I am fully responsible for anything they do not cover. By signing I am agreeing to these terms.

_____ I give permission to leave detailed messages (appointments, payments etc) on the phone number on file.

_____ I give permission to leave test results (treatment, labs) on the phone number on file.

_____ I understand all test results must be reviewed by a physician during an office visit before copies of results are given.

_____ If another office requires a copy, I will have them call **Center for Arthritis & Osteoporosis** directly to make the request.

I authorize the release of information including diagnosis and/or records including examinations rendered to me and claim information. This information may be released to the following people:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

◯ Do not release my information to anyone. (This release of information will remain in effect until terminated by me in writing)

_____
Patient Name

_____
Patient Signature Date

Patient Acknowledgement of Receipt of Privacy Practices Notice

I,____,hereby acknowledgethat I have reviewed and received a c opy of this office’s Notice of Privacy Practice explaining:

☐ How this office will use and disclose my protected health information. ☐ Myprivacy rights in regards to my protected health information.

☐ This office's obligation concerning the use and disclosure of my protected health information.

I understand that this Notice of Privacy Practices may be revised and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any concerns, I may contact:

Center for Arthritis & Osteoporosis 3100 Princeton Pike, Lawrenceville Township, NJ 08648 Phone No. (609-910-5556)

For additional Information, visit www.hhs.gov/ocr.privacy/

Patient or Patient Representative

Signature:______________________________________Date: ____________________

::

OFFICE USE ONLY:

We made a detailed effort to obtain, acknowledgement of ____________________________receipt of our Notice of Privacy Practices. Despite our efforts, we were unable to obtain acknowledgement for the reasons stated below:

☐ Patient refused to sign (date of refusal)__________/________/________

☐ Communication barriers prevented obtaining acknowledgment

☐ An Emergency situation prevented us from obtaining acknowledgment

☐ Other:

Attempt made by:______________________________________Date:__________________________

CAROSP
CENTER FOR ARTHRITIS & OSTEOPOROSIS, P.C.
RHEUMATOLOGY

Humaira Adenwalla, M.D.

BONE HEALTH (OSTEOPOROSIS/*O*STEOPENIA)
SCREENING QUESTIONNAIRE

TODAY'S DATE:_____

LASTNAME:_____ FIRST NAME:_____

RISK FACTORS:

Have you ever fractured/broken a bone? ◯ Yes ◯ No
Has your mother/father ever fractured/broken a bone? ◯ Yes ◯ No
Do you smoke or use tobacco products? ◯ Yes ◯ No
Do you drink more than three alcoholic drinks a day? ◯ Yes ◯ No
Are you on steroids/immunosuppressants? ◯ Yes ◯ No
Do you have rheumatoid arthritis? ◯ Yes ◯ No
Have you ever had a bone density test (DEXA) to check for Osteoporosis/Osteopenia? ◯ Yes ◯ No

If you had a bone density test:

Where:_____ Date of test:_____

Do you know the results? [ ] normal // [ ] Osteopenia // [ ] Osteoporosis

FOR STAFF USE ONLY:
No risk factors

Female: AGE 50-64/ Male: AGE 50-69 → **NO DEXA REQUIRED**

WITH RISK FACTORS FROM ABOVE:

Female: AGE 50-64 / Male: AGE 50-69 → **PROCEED TO ORDER DEXA**

3100 Princeton Pike | Lawrenceville, New Jersey 08648

Phone: (609) - 910 - 5556

Fax:

CAROSP
CENTER FOR ARTHRITIS & OSTEOPOROSIS, P.C.
RHEUMATOLOGY

Humaira Adenwalla, M.D.

PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the appropriate consumption of any such medicine she'll be my sole responsibility or the responsibility of my guardian who has attended this consultation. I agree to properly follow the prescribed dosage and frequency of these medicines as recommended by my physician.

I understand that if a doctor in this office refers me to see another physician or receive other or additional testing which may be but not completely limited to, a blood test, and MRI, or CT scan, the pursuit of this recommendation in a timely manner is important to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this practice to constantly follow up to ensure that I have followed these recommendations. Therefore, I understand if I failed to see the specialist or obtain the test for which I was referred immediately, this can be a source of risk to my current health and increase my future health risk.

I understand that it is solely my responsibility to follow the advice given to me by any medical personnel in this office and any bad health outcome from my failure to pursue the advice of either my physician or the healthcare provider is expected.

Signature:_____ Date:_____

3100 Princeton Pike | Lawrenceville, New Jersey 08648

Phone: (609) - 910 - 5556

Fax: