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Rheumatology Associates of Long Island, LLP

Practice Limited to
Arthritis and Rheumatology
Diplomates American Board of Internal Medicine
Sub Specialty Rheumatology

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TO: OUR PATIENTS

REGARDING: CHECK-IN AND CHECK-OUT PROCEDURES CO-PAYMENT

RALI has procedures for check-in, check-out, return visit scheduling, and co-payment collection. At the check-in desk, the staff member will present you with a copy of your:

- 1) **Patient Information Sheet.** You will be asked to review the information and to be certain that it is correct. If the information needs to be updated, please inform the staff at that time. If there is no need to make corrections you will be asked to sign off on the sheet we will do this at every visit. We recognize that this may seem repetitious to those of you whose information remains unchanged. Our staff handles approximately 100 pieces of return mail a week from patients whose information has changed. Thus, we are taking these steps to ensure our ability to communicate with you, and on your behalf when necessary.
- 2) At the check-in desk, you will also be reminded that a co-payment is due at the time of your visit, and the co-payment will be collected at the check-out. Collection of co-payments by the office is required by both insurers and by Medicare. RALI does not make Medicare or insurance company law, or insurance company policy. The check-in and check-out staff is not empowered to make exceptions to co-payment collection policy. When your insurance plan requires a referral for you to see one of the doctors, we must have that referral or we may be forced to re-schedule your visit.
- 3) You must visit the check-out desk before leaving the office. The check-out desk will schedule your return visit. The scheduling of return visits is to be done at the time of check-out. We ask for your cooperation in the regard.

Patient Name _____ Date _____

Please fill in names of all doctors next to their Specialty

Allergist

Cardiologist

Chiropractor

Dermatologist

Endocrinologist

ENT

Gastroenterologist

Nephrologist

Neurologist

OB/GYN

Oncologist/Hematologist

Ophthalmologist

Orthopedist

Pain Management

Family Doctor/PCP/Internist

Psychiatrist

Psychologist

Pulmonologist

Urologist

Vascular

Past Medications

Please review this list of arthritis medications. Check circle any that you have taken in the PAST

Anti-Inflammatories (NSAIDs)

& Sterioids

Arthrotec
Celebrex
Clinoril/Sulinda
Daypro/Oxaprozin
Dolobid Diflunisal
Feldene/Piroxicam
Indocin
Lodine/Etodolac
Motrin/Ibuprofen/Aleve
Naprosyn
Ketoprofen
Voltaren/Diclofenac
Other:

Rheumatic Biologics

Actemra
Cimzia
Enbrel
Humira
Orencia
Remicade
Rituxan
Simponi Aria
Benlysta
Stelara
Cosentyx
Other:

Pain Relievers/Narcotics

Hydrocodone
Oxycodone
Codeine
Fentanyl
Dilaudid
Methamphetamine
Methadone
Demerol
Dexedrine
Other:

Disease Modifying Anti-Rheumatic Drugs (DMARDS)

Arava (leflunomide)
Cytosan (Cyclophosphamide)
Xeljanz/Tofacitinib
Otezla
Imuran (Azathioprine)
Methotrexate (Rheumatrex)
Neoral (Cyclosporine)
Plaquenil (Hydroxychloroquine)
Prednisone/ Cortisone
Sulfasalazine (Azulfidine)
Other:

Fibromyalgia Medication

Lyrica
Cymbalta
Savella
Gabapentine/Neurotin
Tramadol/Ultram/Ultracet
Cyclobenzaprine
Nortriptyline
Amitriptyline/Elavil
Other:

Osteoporosis

Fosamax/Alendronate
Actonel/Risedronate
Boniva/Ibandronic acid
Zoledronic acid/Reclast
Prolia
Atelvia
Estrogen
Evista/Raloxfiene
Forteo
Other:

Gout Medication

Clochicine
Uloric
Krystexxa
Probenecid
Lopurin/ Allopurinol
Other:

Knee Injections

Orthovisc
Synvisc
Euflexxa
Hyalgan
Supartz
Other:

Please list any other past medications your doctor should aware of:

Last Name: _____ First Name _____

Personal Health History

Circle any health problems that other doctors have diagnosed you with

Arthritis	GERD
Asthma	Heart problems _____ (type)
Cancer _____ (type)	Hepatitis A,B, or C
Cataract	High blood pressure
Blood Clot	Kidney Problems
Colitis	Osteoarthritis
COPD	Pneumonia
Depression	Seizures
Diabetes I or II	Stroke
High Cholesterol	Depression
Emphysema	Thyroid problems: Hypo/Hyper
Fibromyalgia	Bone Fracture
Anxiety	TB/Positive PPD

Surgical History

<u>Date</u>	<u>Procedure</u>

Last Name: _____ First Name: _____

Family Health History

Family Member	Age if Alive	Age at Death	Significant Health Problems/Cause of Death
Father			
Mother			
Sibling (Male/Female)			
Sibling (Male/Female)			
Sibling (Male/Female)			
Sibling (Male/Female)			
Sibling (Male/Female)			

Child (Male/Female)	D.O.B	Age at Death	Significant Health Problems/Cause of Death

Last Name: _____ First Name: _____

Social History

Marital Status:

Single Partnered Married Separated Divorced Widowed

Exercise:

None

Type: _____

Frequency: _____ per week

Caffeine:

None Coffee Tea Cola

of Cups per Day

Tobacco:

Yes No

Cigarettes Cigars

of years _____ or Year that you Quit _____

Alcohol:

Yes No

How many drinks per week? _____

Recreational drugs: (*non-medical*)

Yes No

If yes please list: _____

Last Name: _____ First Name: _____

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1200 South Avenue
Staten Island, NY 1110314
Phone: (718) 698-3777
Fax: (718) 698- 8777

Name _____

Account _____

Notification Policy

It is our policy not to release confidential and/or unauthorized information by home telephone, answering Machine, work telephone, voice mail, cell phone/ or pager. When returning calls and an answering machine picks up; we do not leave a message unless it is an appointment reminder. Information also will not be left with an unauthorized person who may answer the phone.

If you would like to have information released to someone other than yourself, please complete the following:

I authorize the staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

___yes ___no Home telephone _____

___yes ___no Home Answering Machine _____

___yes ___no Fax Home _____

___yes ___no Fax Work _____

___yes ___no Work phone/Voicemail _____

___yes ___no Cell phone/Voicemail _____

___yes ___no E-mail _____

___yes ___no Pager _____

Please list names of authorized people we may leave messages with (i.e. spouse, boyfriend, girlfriend, parent, grandparent etc.):

Name _____ Relationship _____ yes ___ no ___

Name _____ Relationship _____ yes ___ no ___

Name _____ Relationship _____ yes ___ no ___

Who may we discuss your financial situation with?

Name _____ Relationship _____ yes ___ no ___

Name _____ Relationship _____ yes ___ no ___

SIGNATURE (Patient/Guardian)

DATE