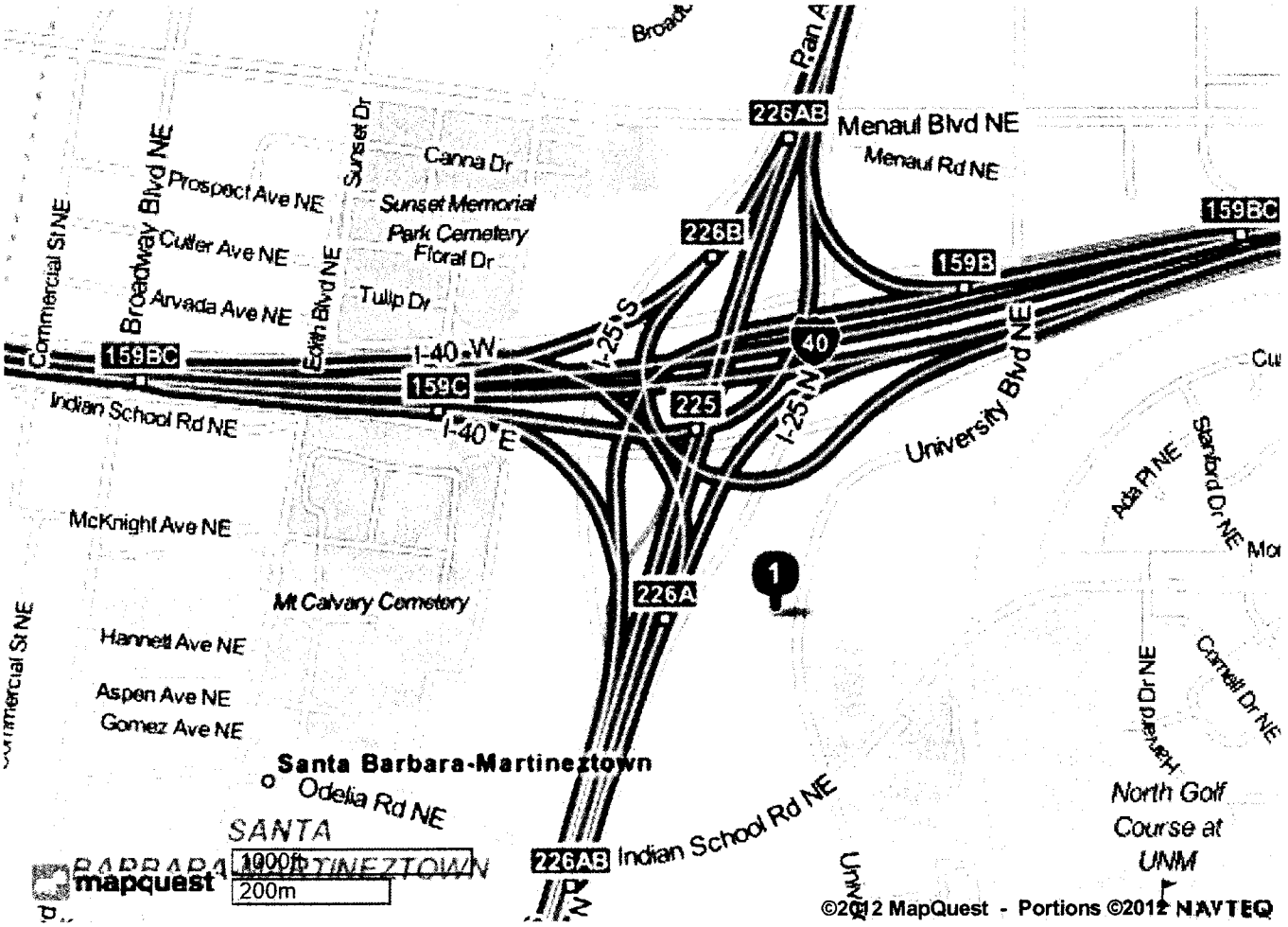
Directions:

From I-40 going East - Exit 4th Street.
Follow frontage road to University
Turn Right on to University
Follow University you will find us on the Right hand side

From I-40 going West - Exit University
At University turn Left
Pass under I-40
Follow University you will find us on the right hand side

From I-25 going South - Exit Comanche, Candelaria, Menaul (Exit 227)
3rd light on exit is Menaul - at Menaul turn left
the first light is University - turn Right
Follow University under I-40 we will be on the right hand side

From I-25 going North - Exit Lomas
Turn right on Lomas go East to University
Turn Left on to University
Pass Indian School (light)
Look for our address on the left hand side



ALBUQUERQUE CENTER FOR RHEUMATOLOGY
1617 University NE
Albuquerque, NM 87102
Phone 505-341-4148 Fax 505-345-9914

OFFICE POLICIES
(Please keep this page for future reference)

Office hours: Monday – Thursday (8:00AM - 4:30PM) and Friday (CLOSED). After hours, the doctor on call may be reached by calling (505) 857-3865.

Financial Policies: Co-payments, deductibles, and any outstanding balances are due at the time of your visit. The office accepts payment by cash, check, Visa, and MasterCard. If a check is returned for insufficient funds, a $35 fee will be added to your account.

Appointments: If you are a new patient, please arrive **30** minutes prior to your scheduled appointment. If you are established patient, please arrive **15** minutes prior to your scheduled appointment. If you are more than 10 minutes late, for any reason, you may have to reschedule your appointment.

Cancellation Policy: 24 hour advance notice is required if you need to cancel or reschedule your appointment. Failure to show for your appointment, without 24 hour notice, or repeated cancellations without notice may result in a charge of $50 added to your account or possible dismissal from the practice. New patients who cancel or do not show to their initial visit will not be rescheduled to be seen.

Insurance: It is your responsibility to verify the physician's participation in your insurance network and obtain any required referrals prior to your visit. Your primary care doctor's office will assist you in the referral process. You must have the referral prior to your visit if your insurance plan requires one or we will be unable to see you.

Prescription refills: Please call your pharmacy directly with refill requests. The pharmacy will notify the office of your request. However, if it is a mail order prescription or narcotic (which requires an original prescription), please call the office directly for refill requests. We require at least a 48 hour notice on prescription refills, so plan ahead in advance. Requests received on Friday will be processed on Monday, or Tuesday after a Monday holiday.

Labs, X-Rays and tests: The office will notify you of your results by mail or phone. If you have not heard from us within two weeks of your test, please call the office.

Please feel free to contact the office with any questions or concerns you may have.

The Physicians and Staff of Albuquerque Center for Rheumatology, P.C.

I have reviewed and received a copy of the Office Policies and agree to abide by them.

_____ _____
Signature Date

PATIENT INFORMATION SHEET

(Please Print)

Demographics

Name: _____ Address: _____

City:_____ State:_____ Zip:_____ Phone: _____

Date of birth: _____ Social Security Number: _____-_____-_____

Marital Status: __ Married __ Divorced __ Widowed __ Single Sex: ___ Male ___ Female
Spouse's name: _____
Patient's Employer: _____ Phone: _____

Responsible party Information

(Only if patient is NOT the responsible party)

Name: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Relationship to patient: _____
Employer: _____ Work Phone: _____

Insurance Information

Primary Insurance: _____

Member #: _____ Group #: _____

Insured's name: _____ Relationship: ___Self ___Spouse ___Child ___Other

Secondary Insurance: _____

Member #: _____ Group #: _____

Insured's name: _____ Relationship: ___Self ___Spouse ___Child ___Other

(Over)

Medical Authorization

I authorize AR&R to release medical information if it is required: (**A**) to process claims for me and/or my dependants; (**B**) by my PCP and/or referring physician; (**C**) by DDU (for disability claims). By my signature below I authorize payment directly to ALBUQUERQUE CENTER FOR RHEUMATOLOGY for my medical services. Should my insurance company deny payment for services not covered under my plan, for ANY reason, **I accept full responsibility for payment**. A photocopy of this authorization may be honored.

_____ _____

Insured and/or patient's Signature Date

Appointment Confirmation

I am giving AR&R permission to confirm my appointments the day before _____YES _____ NO.
I also authorize confirmation of my appointments to be left on my voicemail _____YES _____NO.

Authorization to release information

If I am ever unable to pick-up my prescription or medical records from ACR or am unable to discuss my medical condition with the doctor I authorize this information to be released to:

Name: _____ Relationship: ___Spouse ___Daughter/Son ___Sister/Brother ___Other

This information will be released by Dr. _____ or any of their available staff.

Primary Care Physician

Name: _____ _____ Phone: _____ Fax: _____

Address: _____ _____City: _____ State: _____ Zip:_____

Referring Physician: _____ _____
(if different from above)

ALBUQUERQUE CENTER FOR RHEUMATOLOGY
1617 University NE
Albuquerque, NM 87102
Phone 505-341-4148 Fax 505-345-9914

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

Patient's Name_____ **Date of Birth**____/____/_____
(Please Print)

I consent to the use and disclosure of my protected health information (PHI) by Albuquerque Center for Rheumatology (ACR) for the purpose of diagnosing or providing treatment to me, obtaining payment for services rendered, or as necessary to conduct health care operations of ACR. I understand that diagnosis or treatment of me by any physician of ACR may be conditioned upon my consent as evidenced by my signature of this document.

I understand that I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of this practice. ACR is not required to agree to the restrictions that I may request. However, if ACR agrees to my restrictions they are binding on ACR and any physician of ACR.

I have the right to revoke this consent in writing at any time, except to the extent that any physician off ACR or other employees of ACR have taken action in reliance on this consent.

My "protected health information" PHI, means health information, including my demographic information, collected from me and created or received from my physician, another health care provider, a health plan, my employer or a health care clearing house.

This PHI relates to my past, present and future physical or mental health or condition that identifies me, or that there is a reasonable basis to believe the information may identify me.

I understand that I have the right to review ACR's Notice of Privacy Practices prior to signing this document. The ACR Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices describes the type of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of healthcare operations of ACR. The Notice of Privacy Practices for ACR is also provided in the Waiting Room/Lobby. This Notice of Privacy Practices also describes my rights and ACR's duties with respect to my PHI.

ACR reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain revised notice by calling the office and requested a revised copy and have it sent via mail or to pick up at my next appointment.

I have been offered a copy of ACR's Notice of Privacy Practices: Accept_____Decline:_____
Initial Initial

_____ _____
(Signature of Patient) (Date signed)

_____
(Signature of Personal Representative, if patient is unable to sign or under 18 years of age. Written verification of authority to act on behalf of the patient is required)

AMERICAN COLLEGE OF RHEUMATOLOGY

EDUCATION • TREATMENT • RESEARCH

Patient History Form

Date of first appointment: ____/____/____ (MONTH DAY YEAR) Time of appointment: _____ Birthplace: _____

Name: _____ (LAST FIRST MIDDLE INITIAL MAIDEN) Birthdate: ____/____/____ (MONTH DAY YEAR)

Address: _____ (STREET APT#) Age: _____ Sex: ❑ F ❑ M

_____ (CITY STATE ZIP) Telephone: Home (____) _____ Work (____) _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses _____

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/average per week _____

Referred here by: (check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? ❑ Yes ❑ No If yes, Name: _____

Describe briefly your present symptoms: _____

_____

_____

_____

Date symptoms began (approximate): _____ **Example**

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

_____

_____

_____

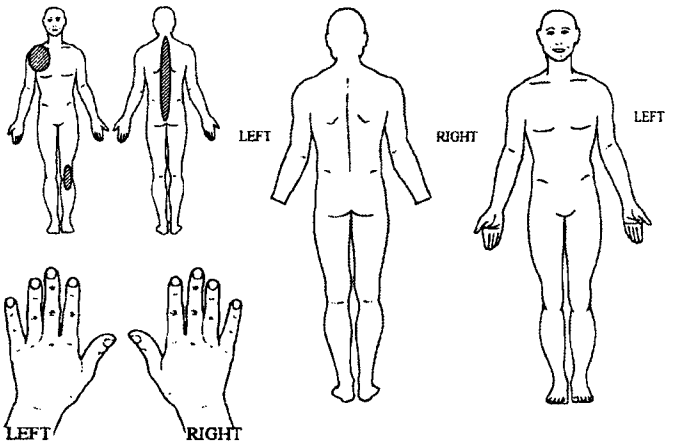
Please list the names of other practitioners you have seen for this problem:

_____

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

Patient's Name _____ Date _____ Physician Initials _____

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram ____/____/____ Date of last eye exam ____/____/____ Date of last chest x-ray ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- ❑ Recent weight gain
  amount _____
- ❑ Recent weight loss
  amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears–Nose–Mouth–Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing

Cardiovascular

- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began:_____

Periods regular? ❑ Yes ❑ No

How many days apart? _____

Date of last period? ____/____/____/

Date of last pap?____/____/____

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ❑ Morning stiffness
  Lasting how long?
  _____ Minutes _____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient's Name _____ Date _____ Physician Initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago?_____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No
If yes, please list: _____

_____

Do you exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week_____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

PAST MEDICAL HISTORY

Do you now or have you ever had: *(check if "yes")*

❑ Cancer	❑ Heart problems	❑ Asthma
❑ Goiter	❑ Leukemia	❑ Stroke
❑ Cataracts	❑ Diabetes	❑ Epilepsy
❑ Nervous breakdown	❑ Stomach ulcers	❑ Rheumatic fever
❑ Bad headaches	❑ Jaundice	❑ Colitis
❑ Kidney disease	❑ Pneumonia	❑ Psoriasis
❑ Anemia	❑ HIV/AIDS	❑ High Blood Pressure
❑ Emphysema	❑ Glaucoma	❑ Tuberculosis

Other significant illness (please list) _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

Previous Operations

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes Describe:_____

Any other serious injuries? ❑ No ❑ Yes Describe:_____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

_____

Do you know of any blood relative who has or had: (check and give relationship)

❑ Cancer _____	❑ Heart disease _____	❑ Rheumatic fever_____	❑ Tuberculosis _____
❑ Leukemia _____	❑ High blood pressure _____	❑ Epilepsy_____	❑ Diabetes _____
❑ Stroke _____	❑ Bleeding tendency _____	❑ Asthma _____	❑ Goiter _____
❑ Colitis _____	❑ Alcoholism_____	❑ Psoriasis _____	

Patient's Name _____ Date _____ Physician Initials _____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

_____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)		❑	❑	❑	
Codeine (Vicodin, Tylenol 3)		❑	❑	❑	
Propoxyphene (Darvon/Darvocet)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		❑	❑	❑	
Gold shots (Myochrysine or Solganol)		❑	❑	❑	
Hydroxychloroquine (Plaquenil)		❑	❑	❑	
Penicillamine (Cuprimine or Depen)		❑	❑	❑	
Methotrexate (Rheumatrex)		❑	❑	❑	
Azathioprine (Imuran)		❑	❑	❑	
Sulfasalazine (Azulfidine)		❑	❑	❑	
Quinacrine (Atabrine)		❑	❑	❑	
Cyclophosphamide (Cytoxan)		❑	❑	❑	
Cyclosporine A (Sandimmune or Neoral)		❑	❑	❑	
Etanercept (Enbrel)		❑	❑	❑	
Infliximab (Remicade)		❑	❑	❑	
Prosorba Column		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient's Name _____ Date _____ Physician Initials _____

PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		❑	❑	❑	
Alendronate (Fosamax)		❑	❑	❑	
Etidronate (Didronel)		❑	❑	❑	
Raloxifene (Evista)		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal (Miacalcin, Calcimar)		❑	❑	❑	
Risedronate (Actonel)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid (Benemid)		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol (Zyloprim/Lopurin)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen (Nolvadex)		❑	❑	❑	
Tiludronate (Skelid)		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyalgan/Synvisc injections		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	
Please list supplements:					

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list: _____

_____

_____

_____

_____

Patient's Name _____ Date _____ Physician Initials _____

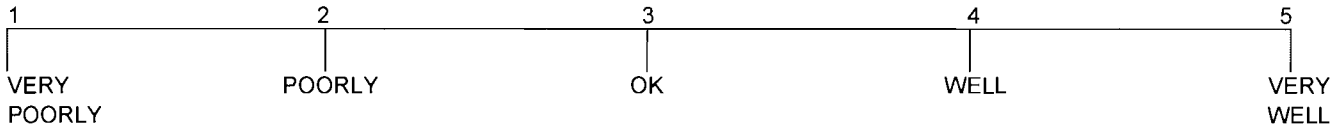
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No If yes, how many? _____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework?_____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from chair?	❑	❑	❑
Touching your feet while seated?	❑	❑	❑
Reaching behind your back?	❑	❑	❑
Reaching behind your head?	❑	❑	❑
Dressing yourself?	❑	❑	❑
Going to sleep?	❑	❑	❑
Staying asleep due to pain?	❑	❑	❑
Obtaining restful sleep?	❑	❑	❑
Bathing?	❑	❑	❑
Eating?	❑	❑	❑
Working?	❑	❑	❑
Getting along with family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness?	❑	❑	❑
Do you use a cane, crutches, as walker or a wheelchair? (circle one)	❑	❑	❑

What is the hardest thing for you to do?_____

Are you receiving disability? Yes ❑ No ❑

Are you applying for disability? Yes ❑ No ❑

Do you have a medically related lawsuit pending? Yes ❑ No ❑

Patient's Name _____ Date _____ Physician Initials _____

Albuquerque Center for Rheumatology, P.C.

☐ **Scott Stoerner, MD**
☐ **Jacqueline Dean, MD**
☐ **Leroy Pacheco, MD**

1617 University Blvd. NE
Albuquerque, NM 87102
Phone #: (505) 341-4148
Fax #: (505) 345-9914

RELEASE OF PATIENT INFORMATION

Patient Name: _____ **D.O.B.:** _____

I hereby authorize the release of medical information obtained in the Diagnosis and Treatment:

From: _____
_____
_____
Fax#_____

To: **Albuquerque Rehab. & Rheumatology**
1617 University Blvd. NE
Albuquerque, NM 87102
Phone#(505)341-4148/Fax#(505)345-9914

The disclosure of the following information is for the purpose of treatment. It shall be limited to the specific types listed below:

All Medical Records inclusive of:

- ○ **Summary Of All Records**
- ○ **Labs**
- ○ **Radiographic Studies**
- ○ **Office Notes**
- ○ **Hospital H&P & D/C Summary**
- ○ **Hospital Consultation**

1- This authorization is voluntary and I may refuse to agree to its terms without affecting any of my rights to receive health care at the Practice.
2- This authorization may be revoked at any time by notifying the Practice in writing at the above address to the attention "Privacy Officer."
3- The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4- The information used or disclosed pursuant to this Authorization may be subject to being disclosed again by the recipient and thus this information will no longer be protected by federal privacy regulations.
5- My health care and payment for my healthcare will not be affected if I do not sign this form.
6- I may see and copy the information described in this form, if I ask for it, and would be able to obtain copy of this form after I have signed it.
7- This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.
8- This authorization is valid as of the date I have signed below and shall remain valid for a period of one year.
9- I understand that this authorization may include the release of information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral, developmental disabilities or mental health services or conditions. It may include the release of information pertaining to the treatment for alcohol and drug use.

Initials of patient: _____ .

_____ _____ _____
Patient Signature **Date** **Witness**