

Shaili Deveshwar MD FACR
American Board of Rheumatology Certified

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

Patient History: (Please List Current Problem)

Please list if you suffer from any chronic conditions

Please list Medications: _____

Please list Medication Allergies:

Please list hospital admissions:

Year Reason/Operation

Year Reason/Operation

Year Reason/Operation

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				
Mother's Mom				
Mother's Dad				
Father's Mom				
Father's Dad				
Bro/Sis				
Bro/Sis				
Bro/Sis				

Health of children: _____

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

- | | | | | |
|----------------------------|----------------------|------------------------------|-------------------------|--------------|
| Rheumatoid Arthritis _____ | Osteoarthritis _____ | Ankylosing Spondylitis _____ | Other Arthritis _____ | Stroke _____ |
| Lupus _____ | Gout _____ | Osteoporosis _____ | Psoriasis _____ | Goiter _____ |
| Colitis _____ | Heart disease _____ | Rheumatic Fever _____ | Tuberculosis _____ | Asthma _____ |
| Leukemia _____ | Kidney Disease _____ | Epilepsy _____ | Diabetes _____ | |
| Cancer _____ | Alcoholism _____ | High Blood Pressure _____ | Vasculitis _____ | |
| Sarcoidosis _____ | Fibromyalgia _____ | Multiple Sclerosis _____ | Bleeding tendency _____ | |

NAME: _____ DOB: _____

SYSTEMIC REVIEW (Please circle all that apply to YOU.)

CONSTITUTIONAL

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

EYES

- Dryness
- Eye pain
- Redness
- Loss of Vision
- Double blurred vision
- Feels like something in eye
- Itching in eye

RESPIRATORY

- Shortness of breath
- Difficulty in breathing at night
- Swollen legs and 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
- Heart Burn

GASTROURINARY

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

Smoking _____ per day _____ # of years _____

Alcohol _____ per week _____

Coffee/Tea _____ cups per day _____

Exercise _____ minutes _____ times per week _____

EAR-NOSE-MOUTH-THROAT

- Loss of taste
- Bleeding gums
- Difficulty swallowing
- Runny nose
- Frequent sore throats
- Sore tongue
- Ringing in ears
- Loss of Hearing
- Nosebleeds
- Loss of Smell
- Dryness in nose
- Sore in mouth
- Hoarseness
- Dryness of mouth

SKIN AND/OR BREAST

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive (Sun Allergy)
- Tightness
- Nodule/Bumps
- Hair Loss
- Pain or color changes of hands or feet in the cold

NEUROLOGICAL

- Headaches
- Dizziness
- Fainting
- Muscle Spasm
- Loss of Consciousness
- Pain/Tingling of hands and feet
- Memory loss
- Night Sweats

PSYCHIATRIC

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

CARDIOVASCULAR

- Pain in chest
- High blood Pressure
- Heart Murmurs
- Irregular heart beat

IMMUNOLOGIC

- Susceptible to infections
- Frequent sneezing

MUSCULOSKELETAL

- Morning stiffness
- Lasting how long _____ mins _____ hrs

- Muscle tenderness
- Muscle weakness
- Joint Swelling

ENDOCRINE

- Excessive thirst

HEMATOLOGIC

- Swollen glands
- Tender glands
- Anemia
- Bleeding tendency
- Transfusion

FEMALES: Menstrual History

Regular _____ Irregular _____ Date of last menstrual period _____

Pain/Cramps with menstrual flow _____ Flushing Menopause _____

Date of Last Pap Test _____ Date of last mammogram _____

of pregnancies _____ #live births _____ # of miscarriages _____

Birth control method _____

Please bring all your recent Xrays and lab work along with you.

Name:

Chart:

Date:

Southeastern Orthopaedic Specialists, PA

Financial & Insurance Policies

Murphy Wainer Orthopedics, The Sports Medicine & Orthopaedics Center,
Guilford Orthopaedics & Sports Medicine Center, Piedmont Orthopedics

Insurance co-pays are due at the time of your appointment and will be collected at check in. Your insurance policies may require you to make a copayment for an office visit and/or medical service, therefore payment is required on the date of service

A \$20.00 service fee will be charged if the co-pay is not paid at the time of service.

The payment collected at the time of service is an estimate based on the information available to us at the time of service. Any remaining balance after the patient's insurance processes and pays the claim is the responsibility of the patient.

We are contracted with most major insurance carriers. **It is the patient's responsibility to verify benefits/limitations and physician participation with their carrier. Many insurance companies require authorization for visits.** If required, please obtain authorization prior to your visit. **Failure to provide authorization may result in the rescheduling and/or cancellation of your appointment.** There may be services provided that your insurance carrier will not cover. Please verify and understand your benefits. **You agree to pay any portion not covered by your insurance carrier.**

Payment requirements if you have NO insurance: A minimum deposit of \$250.00 is required at check in of the initial visit. All other charges are due at time of service unless other arrangements are approved by us in advance in writing.

Patient Balances: When you receive a statement from our facility, payment is due upon receipt of the statement, unless other arrangements have been approved by the facility in writing.

A \$25.00 service fee will be charged for returned checks. This charge will be applied to your account and is due immediately.

Collection Agencies: Patients who do not respond to our efforts to collect an overdue balance may be turned over to an outside collection agency. If this becomes necessary, we will attach a 25% collection fee.

All patients are required to present with a valid Photo ID at check in. A minor child (under 18) must be accompanied by a parent or legal guardian who will present their Photo ID. NEW PATIENTS UNDER THE AGE OF 18 MUST BE ACCOMPANIED AT THE FIRST VISIT WITH PARENT OR LEGAL GUARDIAN. At the follow up appointment the MINOR may attend themselves WITH A WRITTEN STATEMENT PROVIDING AUTHORIZATION TO TREAT MINOR WITHOUT PARENT OR GUARDIAN. This would be required at each visit.

Divorce: In cases of divorce or separation, the parent authorizing treatment for the child/children will be the parent responsible for charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

I have read this Financial Policy and understand that I am ultimately responsible for the charges incurred.

Print Patient Name: _____

Sign Patient/Guarantor Signature: _____

Date: _____