

RHEUMATIC DISEASE ASSOCIATES, LTD

**PATIENT REGISTRATION INFORMATION**

DATE \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

NAME \_\_\_\_\_  
LAST FIRST MIDDLE NAME

DATE OF BIRTH \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

PATIENT OCCUPATION \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

PATIENT EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SPOUSE'S SOC. SEC. # \_\_\_\_\_ SPOUSE'S DATE OF BIRTH \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_

EMERGENCY NAME & NUMBER \_\_\_\_\_  
NAME ADDRESS PHONE

PRIMARY PHYSICIAN \_\_\_\_\_  
NAME ADDRESS PHONE

PHARMACY \_\_\_\_\_ KNOWN ALLERGIES \_\_\_\_\_  
NAME/PHONE

**INSURANCE INFORMATION**

PRIMARY CARRIER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

GROUP # \_\_\_\_\_ ID# \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

SECONDARY CARRIER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

GROUP # \_\_\_\_\_ ID# \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

PLEASE TURN PAGE AND COMPLETE INFORMATION

VISIT OUR WEBSITE: [www.arthritispa.com](http://www.arthritispa.com)

**AUTHORIZATIONS**

**ALL PATIENTS**

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or another physician's office.

I hereby authorize direct payment of medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, Private Insurance, and any other health plan to Rheumatic Disease Associates, Ltd.

I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date

**MEDICARE PATIENTS**

I request that payment of authorized Medicare/Medigap benefits be made to me or on my behalf to Rheumatic Disease Associates, Ltd. for any services furnished me by Rheumatic Disease Associates, Ltd. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

\_\_\_\_\_  
Medicare Beneficiary Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medicare Number

RHEUMATIC DISEASE ASSOCIATES, LTD.  
C. Michael Franklin, M.D., F.A.C.P., F.A.C.R.  
Charles H. Pritchard, M.D., F.A.C.R.  
Mark Lopatin, M.D., F.A.C.P., F.A.C.R.  
David J. Chesner, D.O., F.A.C.R.  
Elana R. Eisner, M.D.  
Dennis A. Jerdan, M.D.  
Timothy R. Howard, DO  
Joan Rooney, CRNP  
(215) 657-6776

Please complete this questionnaire or fill it out on our secure website: [www.arthritispa.com](http://www.arthritispa.com). Ask your doctor or his staff to help you if necessary. YOUR ANSWERS ARE CONFIDENTIAL.

NAME BIRTH DATE SS#

WHAT PROBLEM(S) BRING YOU TO OUR OFFICE?

PLEASE PROVIDE COMPLETE NAME, ADDRESS, TELEPHONE, AND FAX NUMBER OF YOUR PRIMARY CARE AND REFERRING PHYSICIAN.

HAVE YOU SEEN ANY HEALTH CARE PRACTITIONER (e.g., Doctor, chiropractor, nurse, physical therapist) FOR THE PROBLEM THAT BRINGS YOU HERE?

CURRENT MEDICATIONS: (Please List)

NAME (Generic or Brand)	DOSE	PURPOSE	SIDE EFFECTS
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PAST MEDICATIONS FOR THIS PROBLEM:

WHAT SURGERIES HAVE YOU HAD?

FAMILY HISTORY FOR INHERITED DISEASE (SUCH AS ARTHRITIS, CANCER, DIABETES, OTHER).

FOR WOMEN ONLY: Age at menopause

Do you drink milk?

Do you take vitamins, calcium, or any supplements?

Please list:

If appropriate, would you be interested in participating in Clinical Trials for new treatment of your disease?

Visit our website: [www.arthritispa.com](http://www.arthritispa.com)