Name: _____ _____

First Name *Last Name*

Birth Date: _____ Cell Phone Number: _____

Email Address: _____

Sex: ☐ Male ☐ Female ☐ X

We look forward to providing you with the best medical care, regardless of your insurance plan, but we need to know how to process your claims.

Which medical insurance do you have?

We are in-network for the following plans:

- ☐ **Medicare with PPO supplement**
- ☐ **Medicare with no supplement** (patient responsible for 20% of fees)
- ☐ **Anthem/Blue Cross PPO Plan**
- ☐ **Aetna PPO Plan**
- ☐ **Cigna PPO Plan**
- ☐ **Humana ChoiceCare**
- ☐ **Multiplan**
- ☐ **Scripps Employee Medical Plan**
- ☐ **Three Rivers**
- ☐ **USA MCO**
- ☐ **Health Smart**

We are out-of-network for the plans listed below. If you have one of these plans, we will submit the claim to your insurance, but we request that you make a payment at the time of the visit. Inquire with office staff regarding rates.

- ☐ **PPO plans other than previously listed**
- ☐ **Medicare Advantage Plans**
- ☐ **HMO Plans**
- ☐ **Other, or no insurance**

We understand that filling out extensive forms can be cumbersome, and we appreciate the time you spend completing them.

Forms Can Be Sent To: Office@DoctorB.Care

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Home Address:

Street _____

_____

City _____

State, Zip _____

Phone numbers: Preferred number *(choose one)*

Mobile Phone: _ (was provided on page 1) ____ ☐

Home Phone: _____ ☐

Work Phone: _____ ☐

*Other Phone:*_____ ☐

Place of Birth:_____

If patient works through a personal assistant, please provide assistant name and contact information:

_____

_____

_____

Government regulations require that we document race and ethnicity in the format below:

Race
- ☐ decline to disclose
- ☐ race not known
- ☐ American Indian or Alaskan Native
- ☐ African American or Black
- ☐ White
- ☐ Asian

Ethnicity
- ☐ decline to disclose
- ☐ ethnicity not known
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Marital Status

- ☐ single
- ☐ married
- ☐ divorced
- ☐ widowed
- ☐ partnered
- ☐ Other

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Emergency Contact:

Name: _____ Phone number:_____

Relationship:_____

In case we cannot reach you with urgent and important medical information,
may we relay the information to your emergency contact?
☐ Yes ☐ No

Primary Care Doctor Information:

Name:_____ Office Tel number:_____

Office Fax number:_____

Who referred you to our office? (if different than primary care doctor)

Name:_____ Office Tel number:_____

Office Fax number:_____

Pharmacy Information:

Primary Pharmacy Name: _____

Pharmacy Location: _____

Phone number: _____

Other Pharmacy Name: _____

Other Pharmacy Location: _____

Other Phone number: _____

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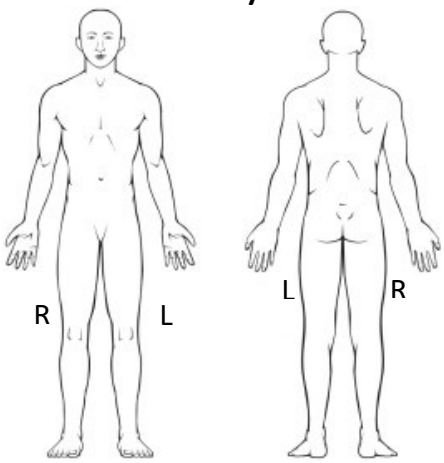
On the line below, please list what brings you into the doctor today:

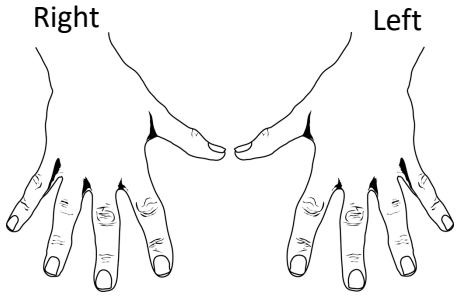
_____

Where do you have pain (please shade in affected areas)?

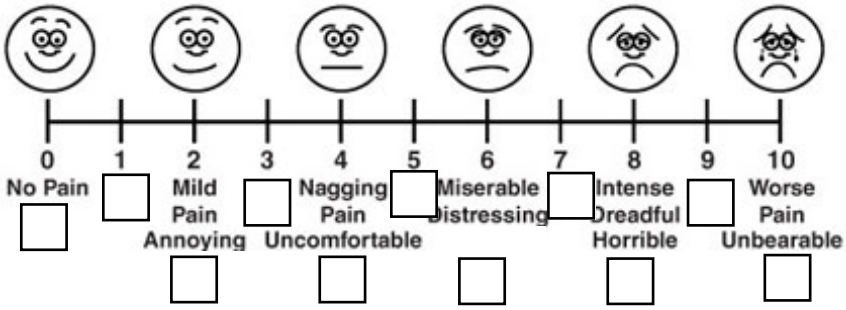
Body:



Hands:



How severe has your pain been in the last few days?



When did this problem start?_____

Pain is most severe in the (check all that apply):

□ morning □ night □ random coming and going
□ evening □ after activity □ constant

What makes your pain feel better?

Over the past couple of weeks, have any of the following symptoms concerned you?

□ sweats
□ fever
□ dry mouth
□ pain with urination
□ skin rash with sun exposure
□ fatigue
□ insomnia
□ black stool
□ severe frequent headaches
□ swollen lymph nodes
□ chest pain
□ eye pain
□ difficulty swallowing
□ ulcers in the mouth
□ dry eyes
□ diarrhea
□ brain fog
□ nausea
□ poor appetite
□ constant blurry vision
□ excessive sleeping
□ shortness of breath
□ cough
□ palpitations
□ blood in the stool
□ more than 5 lbs weight loss
□ Fingers turn white/blue/red in cold
□ allergies
□ depression
□ difficulty rising from a chair due to weakness

□ *none of the above*

Mark any condition which you currently have, or have had in the past:

□diabetes
□high blood pressure
□history of heart attack
□history of stroke
□congestive heart failure
□history of bone fracture
□sleep apnea
□anxiety
□depression
□other mental health difficulties:_____
□taking blood thinner:_____
□infertility
□frequent heartburn
□history of stomach ulcer
□eating disorder (bulimia or anorexia nervosa)
□genetic predisposition to cancer
□rapid loss of hair
□heart condition: _____
□chronic kidney disease or renal insufficiency
□history of cancer
what type?_____
when diagnosed?_____
□history of skin cancer
□basal cell □squamous cell
□melanoma □other_____
□history of leukemia or lymphoma
□hepatitis B
□hepatitis C
□other hepatitis or chronic liver problem: _____
□Crohn's Disease
□Ulcerative Colitis
□asthma
□chronic bronchitis (COPD)
□other lung condition:_____
□history of kidney stones
□predisposition to blood clots
□history of blood clot
□psoriasis, diagnosed by doctor
□history of diverticulitis or diverticulosis
□history of seizure
□hypothyroid (low thyroid)
□hyperthyroid disease (Grave's disease)
□Uveitis, iritis, or other autoimmune eye disease
□frequent infections, requiring antibiotics more than twice a year
□history of tuberculosis
□positive PPD test or positive blood test for dormant tuberculosis
□HIV infection
□history of histoplasmosis or Cryptococcus infection (valley fever)
□history of tick bite
□history of lyme disease
□*Other:*_____

Women only

□currently pregnant
□miscarriages
if yes, how many ___,
and how far along in the pregnancy _____?)
□excessive menstrual bleeding
□menopause
□vaginal dryness
□history of vaginal or labial ulcers
□urine tract infections more than twice a year
□genital herpes

Men only

□history of urine tract infection
□history of ulcers on penis or scrotum
□genital herpes

□*None of the above apply to me*

Surgical History:

Surgery Type:	Approximate Date:

Are you allergic to any medications? □ No □ Yes

Medication:_____ Reaction:_____

Medication:_____ Reaction:_____

Medication:_____ Reaction:_____

Medication:_____ Reaction:_____

Medication:_____ Reaction:_____

Medications:

Please include vitamins, supplements, and herbal agents.
If you brought a list, we will be happy to accept it, and you may skip this section.

Medication Name	Milligrams per tablet	How many pills per dose?	How many doses per day?
Example: **Advil**	**200mg**	**2 pills**	**Twice a day**

Have you received the following vaccines?

COVID vaccine?
□ No
□ Yes: approximate date of most recent dose: _____

Zoster (shingles) vaccine?
□ No
□ Yes: approximate date of most recent dose:_____

Flu vaccine (influenza)?
□ Never
□ Yes: approximate date of recent dose:_____

Pneumococcal vaccine?
□ No
□ Yes: approximate date of most recent dose:_____

Osteoporosis Screening:

Have you ever had a bone density test for osteoporosis? □ Yes □ No

If yes, approximately when and where was the most recent exam? _____

What were the results? □ Normal □ Osteopenia □ Osteoporosis

What is your current height and weight:_____

What is/was your occupation? _____ □ Retired

Who shares your home? _____

Smoking habits:
□ Current every day smoker
□ Current some day smoker
□ Former smoker
□ Never smoked

Recreational drug use:
□ Never use
□ Medicinal marijuana
□ Recreational marijuana
□ Other recreational drugs:_____
□ Used regularly in past, but not any more.

Alcoholic beverage habits:
□ Never or rarely drink
□ 1-2 servings per week
□ 3-8 servings per week
□ 9 or more servings per week
□ Used to drink daily, but not any more
□ Current or former member of AA

Additional information: _____

_____

Family Medical History:

Please list which relatives, if any, have the following conditions:

Arthritis of unknown type: _____

Rheumatoid arthritis: _____

Hand osteoarthritis: _____

Hip fracture or Osteoporosis: _____

Lupus: _____

Crohn's Disease: _____

Ulcerative Colitis: _____

Psoriasis: _____

Gout: _____

Other medical conditions of close relatives: _____

_____

_____

□ **Family history unknown**

□ **Family members have no significant medical conditions**

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby request/authorize _____ to release the following information from my healthcare records to the office of **Ami Ben-Artzi, M.D.** for the purpose of continuation of medical care:

( ) ALL RECORDS

( ) History and Physical Exam
( ) Discharge Summary
( ) ER Physician Note/ER Labs
( ) Echo/Stress Test/Cardiac Cath. Report
( ) Endoscopy/EGD/Colonoscopy
( ) Other _____

( ) Progress Notes
( ) Laboratory Reports
( ) Pathology Report
( ) DEXA Scan
( ) Operative Report

This authorization will expire 1 year from the date the authorization was signed.

Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

Patient Name:_____ **Birth date:**_____

Signature_____ **Date**_____

Legal representative (relationship to patient) _____

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NOTICE OF PRIVACY PRACTICES

In accordance with the *Health Insurance Accountability and Portability Act* (HIPPA), you have been provided with a Notice of Privacy that provides information about how we may use and disclose *protected health information* ("PHI") about you. This Notice provides a more complete description of information uses and disclosures.

As a part of your healthcare, we maintain health records that describe your health history, symptoms, examination, test results, diagnosis, treatment, and plan for future care or treatment. This information serves as a basis for planning you care and treatment; a means of communication among other health professionals who contribute to your case; a source of information for applying your diagnosis and healthcare information to bill third parties, a means by which a third party payer can verify that services billed were actually provided; and a tool for routine healthcare operations such as assessing quality and reviewing the delivery of medical services.

You have the right to review our Notice before signing this consent. We will provide you with a copy of the Notice at your request.

You have the right to object to the use or disclosure of your health information. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use of your PHI to provide you with treatment, and collect payment for your care, in accordance with the Notice of Privacy Practices. You have the right to revoke this consent, in writing, except where we already made disclosures in reliance on you prior consent.

Initial: _____ I request the following restrictions to the use or disclosure of my health information:

_____

I am informed of the Notice of Privacy Practices and consent to the use and disclosure of my health information for treatment, payment, and healthcare operations as described therein.

_____ _____

Signature *Date*

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
PH:(800)633-2322 www.mbc.ca.gov

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PATIENT FINANCIAL RESPONSIBILITY POLICY

At Ami Ben-Artzi, MD inc., we strive to provide you with the best possible care. In order to serve this purpose, it is important that you understand your financial responsibility. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability.

Your current and correct insurance card must be presented at the time services are rendered. If your card is not present at the time you receive services, we may not be able to bill your coverage until it is received. If we do not receive your insurance card within 90 days of service, many insurances will no longer allow us to bill them. You may need to seek reimbursement from them directly at that point. If your coverage cannot be verified at the time of service, you will be responsible for payment for all services up front. It is your responsibility to notify us if there are any changes to your insurance, address, phone number or family status at check-in or sooner. It is your responsibility to pay for your copay and/or coinsurance at time of service. If uninsured, it is your responsibility to pay your bill in full at time of service.

If your insurance does not cover any office visit, specifically but without limitation to annual exams, and/or diagnostic testing, and/or treatment, you understand that you are responsible for payment of service and will make immediate, satisfactory arrangements to settle your account. Although we will bill your insurance company for services rendered, you are financially responsible for all services rendered. If payment has not been received within 60 days of billing your health plan, we will contact you for assistance. Should your health plan deny coverage for any reason, you will be responsible for payment within thirty days of your billing statement.

Signature of Patient, Authorized Representative or Responsible Party	Date
Print Name of Patient, Authorized Representative or Responsible Party	Relationship to Patient

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CANCELLATION POLICY

We are dedicated to providing you with excellent rheumatology care and exceptional service. In order to provide the best care to all of our patients we would like to inform you of our policy concerning no-show and same day cancellations.

If you are unable to make it to your appointment, we ask that you provide **advance notice of at least 1 full business day prior to the appointment time**. Please give our office a call or email and we will gladly help you reschedule to a time that works better for you.

For any appointment cancelled less than 24 hours prior to the appointment time, or if prior notice is not given, there will be a cancellation fee applied. The fee is **$100** for a New Patient Appointment and **$50** for a Follow-Up Appointment. This fee is not payable by insurance and is the responsibility of the patient.

I am informed of the cancellation policy and recognize my responsibility to pay the cancellation fees as described above.

_____ _____

Signature *Date*

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