R&O RHEUMATOLOGY&OSTEOPOROSIS | services p.c.
1520 South 70th Street, Suite 200
Lincoln, Nebraska 68506
Tel: (402)464-9000 Fax: (402)464-4447
www.rheumatologyandosteoporosis.com

Amy S. Garwood, M.D.
Jennifer R. Elliott, M.D.
Kayla B. Bruss, MPAS, PA-C
Molly B. Skomer, APRN
Kelsey L. Baxa, APRN
Gary D. Cuddy, PA-C

Hello New Patient,

Welcome to Rheumatology & Osteoporosis Services, the office of Dr. Amy Garwood, Dr. Jennifer Elliott, Kayla Bruss, PA-C, Molly Skomer, APRN, Kelsey Baxa, APRN and Gary Cuddy, PA-C.
As a new patient to our clinic, we request your referring and/or your primary physician to fax your medical records to us. We ask you to complete the enclosed forms and return them to us via mail or fax. We also request you to send in a copy of all insurance cards (front & back, medical and prescription drug cards please). We will call you to schedule your new patient appointment as soon as we receive all the required paperwork.

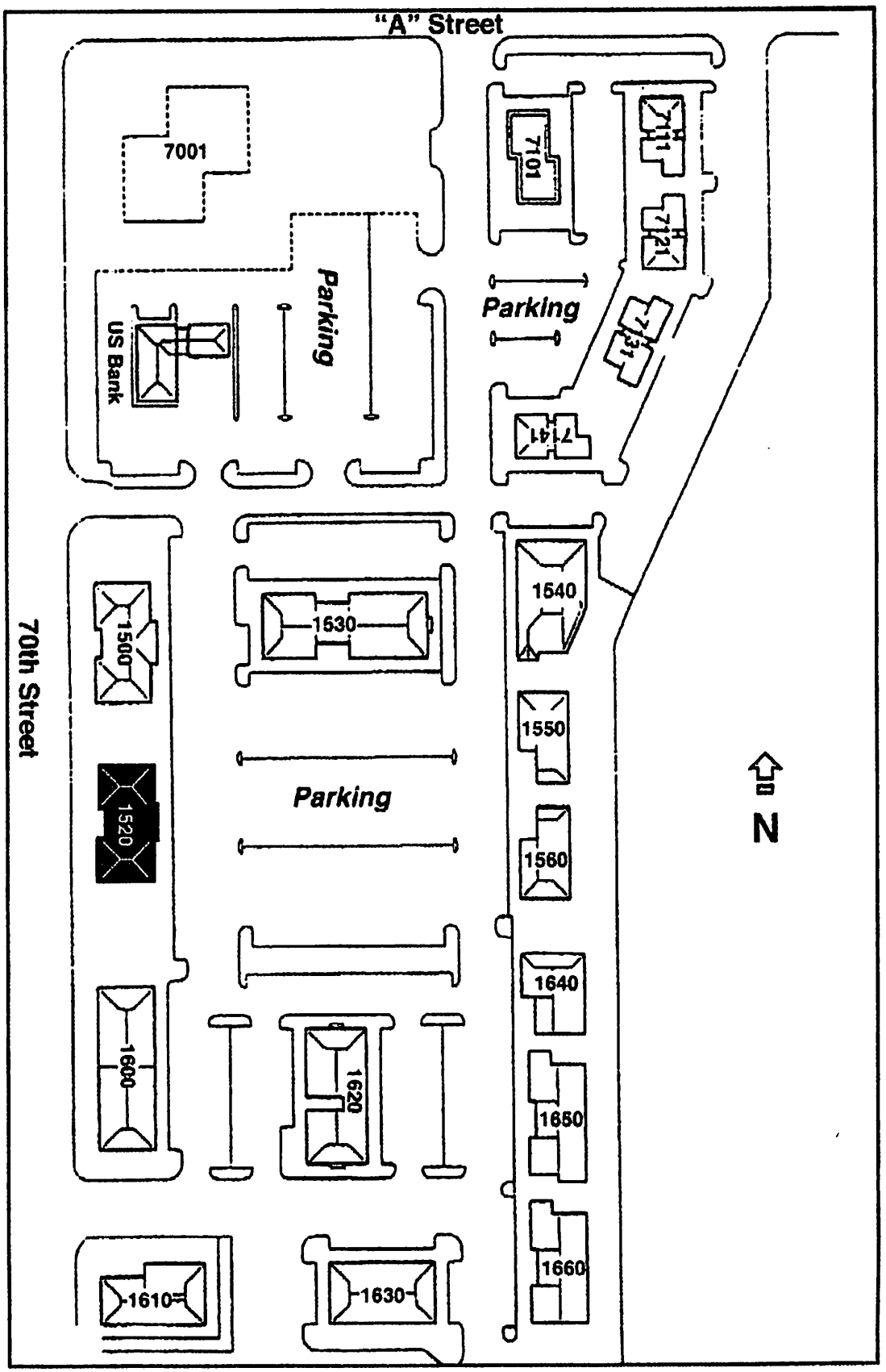
Our address: 1520 S 70th Street, Suite 200 **Fax number: 402-464-4447**

Please arrive 15 minutes prior to your new patient appointment. If you are late, it may be necessary to reschedule your appointment. Due to time constraints, if you no-show your one hour new patient appointment, it may be rescheduled only if approved by the physician.

Checklist for your appointment:

- ☐ **Your current insurance card(s), if you have a different insurance for your prescription drugs, please have that card as well.**
- ☐ **Your specialty office co-pay, if required by your insurance**
- ☐ **If you have had recent medical reports, labs or imaging that would be pertinent to your upcoming appointment, please bring them or have your referring physician send them to us.**

We look forward to meeting and treating you at your upcoming appointment. Please call us with any questions at 402-464-9000.


"A" Street
7001
Parking
US Bank
7101
7111
7121
Parking
7131
7141
1540
1530
1500
1550
Parking
1520
1560
1640
1600
1620
1650
1660
1610
1630
70th Street
N

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FRACTURE LIAISON SERVICE (FLS) BY R&O

NEW PATIENT HISTORY FORM *PLEASE USE BLACK OR BLUE INK ONLY*

Patient Name _____
Last First Middle Initial Maiden

Preferred name if different than above_____ Birthdate: _____/_____/_____ Age:_____

Address_____ Social Security #_____

City_____ State_____ Zip Code_____

Telephone: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Email Address:_____ Preferred Method of Contact: Home Work Cell

Sex: ☐ Male ☐ Female **Are you:** ☐ Right Hand Dominant ☐ Left Hand Dominant ☐ Ambidextrous

Primary Language (circle one): English Other_____ **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐American Indian or Alaska Native ☐Asian ☐ Black or African American ☐White ☐Native Hawaiian or Other Pacific Islander

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

EMERGENCY CONTACT: 1) Name_____ Relationship_____

Phone Number(s)_____

2) Name_____ Relationship_____

Phone Number(s)_____

REFERRAL: Referred here by: ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Heath Professional

Name of person making referral_____

Primary Care Physician (PCP)_____

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

Have you been treated for osteoporosis? ☐ Yes ☐ No If yes, where/by who?_____

PREFERRED PHARMACY:

Local_____ Location_____

Mail Order_____ Location_____

Patient's Name_____ Date_____

PREVIOUS OPERATIONS

Type of Surgery	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

PREVIOUS FRACTURES

Location of Fracture/Type	Year or Age at Fracture	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

FAMILY HISTORY

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

☐ Alcoholism_____ ☐ Diabetes_____ ☐ Hip fracture_____ ☐ Psoriasis_____

☐ Blood clots_____ ☐ Dowager's hump_____ ☐ Hypertension_____ ☐ Stroke_____

☐ Cancer_____ ☐ Elevated urine calcium_____ ☐ Kidney stones_____ ☐ Thyroid disorder_____

☐ Celiac Sprue_____ ☐ Epilepsy_____ ☐ Leukemia_____

☐ Colitis_____ ☐ Heart disease_____ ☐ Osteoporosis_____

Any other conditions that run in your family?_____

SOCIAL HISTORY

Do you drink caffeinated beverages? ☐ Yes ☐ No
Cups/glasses per day_____

Do you smoke? ☐ Yes ☐ No ☐ Past smoker

When did you quit?_____ How many packs per day?_____

How many cigarettes per day?_____

Do you drink alcohol? ☐ Yes ☐ No # drinks/week_____

Do you exercise regularly? ☐ Yes ☐ No

Type_____

Amount per week_____

Do you consume dairy products? ☐ Yes ☐ No

Average number of servings per day_____
Average number of servings per week_____

PAST MEDICAL HISTORY

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

☐ Alcoholism ☐ Diabetes ☐ Liver disease

☐ Anemia ☐ Eating disorder ☐ Osteoporosis

☐ Blood clots ☐ Gastric bypass surgery ☐ Rheumatoid arthritis

☐ Cancer ☐ Heartburn

☐ Celiac Sprue ☐ HIV/AIDS ☐ Seizure disorder

☐ Colitis ☐ Kidney disease ☐ Stomach ulcers

☐ Cushing's disease ☐ Kidney stones ☐ Thyroid disorder

☐ Lactose intolerance

Other significant illness (please list)_____

Medication History: ☐ Steroids ☐ Cortisone ☐ Depo Provera
Describe: _____

Patient's Name_____ Date_____

ALLERGIES (medications, latex, food, etc.)

Allergic to	Reaction
1.	
2.	
3.	
4.	
5.	

PRESENT MEDICATIONS List all medications you are taking. (Include multiple vitamins, antacids, calcium, Vitamin D, supplements)

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.			☐	☐	☐

PAST OSTEOPOROSIS MEDICATIONS (Please review this list of 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 Generic (Brand) Names	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not at All	
OSTEOPOROSIS MEDS					
Alendronate (Fosamax)		☐	☐	☐	
Ibandronate (Boniva)		☐	☐	☐	
Risedronate (Actonel)		☐	☐	☐	
Zoledronic Acid (Reclast, Zometa)		☐	☐	☐	
Pamidronate (Aredia)		☐	☐	☐	
Teriparatide (Forteo)		☐	☐	☐	
Denosumab (Prolia)		☐	☐	☐	
Raloxifene (Evista)		☐	☐	☐	
Estrogen or Hormone Replacement Therapy (HRT)		☐	☐	☐	
Calcitonin (Miacalcin)		☐	☐	☐	

Date of last bone density test (DXA) _____/_____/_____ **Location**_____

Patient's Name_____ Date_____

SYSTEMS REVIEW

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

Constitutional
- ☐ Falls
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Recent weight gain Amount_____
- ☐ Recent weight loss Amount_____
- ☐ Weakness

Eyes
- ☐ Double or blurred vision
- ☐ Dry eyes
- ☐ Eye pain
- ☐ Eye redness
- ☐ Low vision

Ear-Nose-Mouth-Throat
- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Runny nose
- ☐ Sinus trouble
- ☐ Sores in mouth or nose

Cardiovascular
- ☐ Chest pain
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat

Respiratory
- ☐ Cough
- ☐ Difficulty in breathing at night
- ☐ Pain with breathing
- ☐ Shortness of breath
- ☐ Snoring
- ☐ Swollen legs or feet

Gastrointestinal
- ☐ Black stools
- ☐ Blood in stools
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Stomach pain
- ☐ Vomiting

Genitourinary
- ☐ Blood in urine
- ☐ Difficult urination
- ☐ Getting up at night to pass urine
- ☐ Pain or burning on urination
- ☐ Vaginal dryness

Musculoskeletal
- ☐ Falls
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Morning stiffness
- ☐ Muscle tenderness
- ☐ Muscle weakness

Integumentary (skin)
- ☐ Easy bruising
- ☐ Nodules/bumps
- ☐ Pigment changes to skin
- ☐ Psoriasis
- ☐ Rash

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory loss
- ☐ Muscle spasms
- ☐ Numbness or tingling
- ☐ Restless legs

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Excessive worries

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Swollen glands
- ☐ Tender glands

For Women Only:

Approx. age of menopause_____

Did you have surgical menopause?

☐ Yes ☐ No

Number of pregnancies_____

Number of miscarriages_____

History of irregular periods?

☐ Yes ☐ No

Bleeding after menopause?

☐ Yes ☐ No

Have you ever taken estrogen?

☐ Yes ☐ No

If so, for how long?_____

Patient's Name_____ Date_____

Insurance Information (Please attach copies of all insurance cards including Rx Drug Card)

Primary Insurance Company Name:_____
Insurance company address:_____
Insurance company phone number:_____
Policy number/ID number:_____
Group number:_____
Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
If relationship to insured is other than "Self", please complete below:
Policy Holder (Insured) Name_____
Address_____
Phone Number_____
Date of Birth _____/_____/_____ Employer_____

Secondary Insurance Company Name:_____
Insurance company address:_____
Insurance company phone number:_____
Policy number/ID number:_____
Group number:_____
Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
If relationship to insured is other than "Self", please complete below:
Policy Holder (Insured) Name_____
Address_____
Phone Number_____
Date of Birth _____/_____/_____ Employer_____

Tertiary Insurance Company Name:_____
Insurance company address:_____
Insurance company phone number:_____
Policy number/ID number:_____
Group number:_____
Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
If relationship to insured is other than "Self", please complete below:
Policy Holder (Insured) Name_____
Address_____
Phone Number_____
Date of Birth _____/_____/_____ Employer_____

Rx Drug Coverage
Insurance company name_____
Insurance company phone number_____
Policy number/ID number_____

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• I acknowledge that I understand the **Notice of Privacy Practices** (HIPAA) of R&O.

Check one: I decline to be given a copy of the document_____
I request to be given a copy of the document_____

• I acknowledge that I have received and understand the **Policies and Procedures** of R&O.

• I hereby authorize R&O to file a claim with my insurance company(s) and release any medical information necessary to process my insurance claim. I understand that I am financially responsible for any and all bills accrued at R&O.

• I hereby authorize R&O to view my E-Med electronic medication history.

• I hereby authorize R&O to send my Continuity of Care Document to any physicians relevant in my care.

_____
Printed Name

_____
Signature

_____
Date

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CONSENT TO RELEASE MEDICAL AND BILLING INFORMATION

(Complete this form if you wish to allow others access to your medical and billing information)

Patient Name_____

DOB_____/_____/_____

I, _____, do hereby authorize R&O to release information concerning any and all diagnostic studies and findings contained within my clinic chart (whether performed here or elsewhere), my billing, insurance and other account information to the parties listed below:

TO:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

▪By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient is not required by law to protect the privacy of the information.

▪You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will be valid until further notice.

_____ _____

Signature of Patient Date

Pharmacy Refills

We have moved to an electronic prescription system. If you need refills, we encourage you to contact your pharmacy and your pharmacy will request the refills electronically. To improve your care, we request one week notice on your refills. We may not renew your prescriptions if you have not recently been seen by your physician.

For narcotics or pain medications, we again encourage refills from your pharmacy. We expect at least a one week notice, as these medications need to be prescribed by your own physician. Our policy is that there will not be any early refills. We will not refill after business hours and will not replace any narcotics or pain medications that are lost or stolen.

Samples

We will offer selected samples of medications as available. We do have access to patient assistance medication programs offered by some drug companies to help with costs of drugs for our patients who qualify.

Patient Education

We have resources available to help you learn about diseases and treatments. Remember that we are on your team – and that you LEAD the team. We are focused on patient success at R&O.

Hospital

Our doctors will be available for rheumatologic hospital consultations if needed. If you need to be in the hospital, your hospital care will be coordinated by your primary care doctor, or an in-patient specialist, who will confer with our doctors.

Laboratory

We do not have a lab at R&O. We use Nebraska LabLinc (NLL), Quest Diagnostics and Physicians Laboratory as our primary labs. If you would prefer to have your labs drawn at a different location, we are more than happy to accommodate your request. Please check the back of your insurance card, as there may be a preferred lab for your policy.

LabCorp
5340 South St, Lincoln, NE 68506
Phone: 402-484-5462 Fax: 402-484-5463
Hours: Monday – Friday 7am – 6pm
Saturday 8am – 12pm

Quest Diagnostics
1001 S 70th St, Ste 111, Lincoln, NE 68510
Phone: 402-465-1724 Fax: 402-465-1762
Hours: Monday - Friday 7am-5pm
Saturday 8am-12pm

Physicians Laboratory
7441 O St, Ste 100, Lincoln, NE 68510
Phone: 402-488-7710 Fax 402-488-6941
Hours: Monday – Friday 7:30am-5pm

There is no need to make an appointment. You can get labs drawn at your convenience during normal business hours.

Bone Density Scans (DXA)

Our DXA scanner is available during business hours to measure your bone density. Our physicians are specialists in OSTEOPOROSIS evaluation and treatment. Our whole team will work with you to maximize your bone strength and help prevent fractures.

X-Rays

R&O has an x-ray machine which can provide a full range of x-ray services. Please call ahead of time if you need your x-rays to take to another physician. We prefer you to pick them up, but it is also possible to mail them.

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Policies and Procedures

Telephone

Our phone number is 402-464-9000. Our receptionist will be available to direct your call during business hours. Your physician's nurse will also be available by phone for medical questions or concerns. If you are directed to a voice mail, please leave a message, as calls are returned throughout the day. If you call after business hours, our answering service will take a message for you. Our phones are turned off for lunch from 12:00pm-1:00pm daily.

Appointments

Our schedule helps us see many patients each day. We strive to stay on time and appreciate your prompt arrival for your appointment. We ask that you arrive 15 minutes prior to your scheduled appointment time to complete any necessary paperwork. We ask for a 24-hour cancellation notice if you can't make your appointment. If you do not cancel within 24-hours, this is considered a "no-show" appointment. If a patient "no-shows" three appointments or if a patient "no-shows" their new patient appointment, we may not reschedule them unless approved by the physician or practice administrator. If you are more than 10 minutes late to an appointment, you may be asked to reschedule.

Insurance/Billing/Payments

Every U.S. citizen is now required under the federally mandated Affordable Care Act to be enrolled in a health insurance plan. Our clinic policy will be to assist in filing health insurance claims for our patients who have health insurance coverage. If you have a per visit co-pay under your insurance, you will be required to pay that co-pay at the time of your visit. If your insurance has a high deductible or co-insurance, we will request payments to be made at each visit. Patients without health insurance will be subject to our full charges for all services and will need to come prepared to pay at the time of service.

Please call Deb or Megan with any billing and/or insurance questions you may have. We participate with many insurance carriers including Medicare, Blue Cross/Blue Shield, Midlands Choice, United Healthcare, Coventry and several other PPO organizations. However, we recommend you contact you insurance carrier for specific coverage details. We do accept Medicare assignment. Cash, personal checks, MasterCard, Discover and Visa are accepted. There is a $35.00 charge for all returned checks.

Inclement Weather

Please call before you start out if the weather is bad to make sure we are open. If we do end up closing, our phone message will have that information. If you had a scheduled appointment, we will call you later to reschedule.