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
7131
Parking
7141
1540
1530
1500
1550
Parking
1520
1560
1640
1600
1620
1650
1660
1610
1630
70th Street
N

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AMERICAN COLLEGE OF RHEUMATOLOGY
EDUCATION • TREATMENT • RESEARCH

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PLEASE USE BLUE OR BLACK INK ONLY

Patient Name _____
Last First Middle Initial Maiden

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

Address_____ Social Security #_____

City_____ State_____ Zip Code_____ Birthplace:_____

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

Spouse/Significant other: ☐ Alive/Age_____ ☐ Deceased/Age_____ Major Illnesses_____

Name of Spouse _____ Spouse Date of Birth _____/_____/_____

EDUCATION: (Circle highest level attended):
Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School_____

Current Work Status: ☐ Retired ☐ Unemployed ☐ Disabled ☐ Full-time ☐ Part-time # of hours worked/average per week_____

Place of Employment_____ Occupation_____

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:_____

PREFERRED PHARMACY:

Local_____ Location_____

Mail Order_____ Location_____

Patient's Name_____ Date_____ MD Initials_____

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_____

Describe briefly your present symptoms:_____

_____

_____

Date symptoms began (approximate):_____

Diagnosis:_____

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

_____

_____

_____

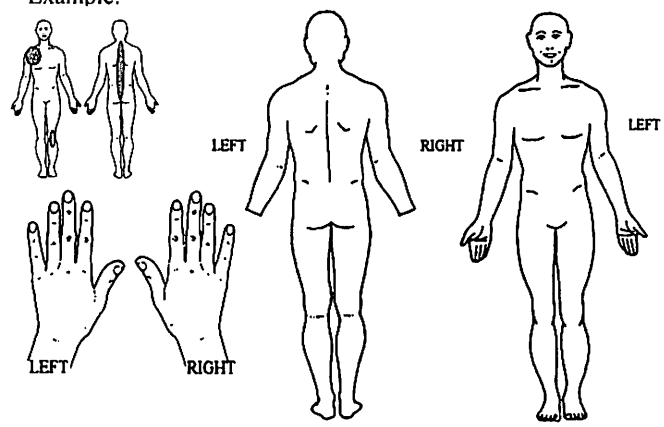
Please list the names of other practitioners you have seen for this problem:

_____

_____

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

Example:



PREVIOUS OPERATIONS

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

Any previous fractures? ☐ Yes ☐ No Describe:_____

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

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
	Ankylosing Spondylitis			Lupus or SLE	
	Arthritis (unknown type)			Osteoarthritis	
	Childhood arthritis			Osteoporosis	
	Gout			Rheumatoid Arthritis	
Other arthritis conditions:					

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:_____

Patient's Name_____ Date_____ MD Initials_____

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

☐ Alcoholism_____ ☐ Colitis_____ ☐ High blood pressure_____ ☐ Rheumatic Fever_____

☐ Asthma_____ ☐ Diabetes_____ ☐ Leukemia_____ ☐ Stroke_____

☐ Bleeding tendency_____ ☐ Epilepsy_____ ☐ Miscarriage_____ ☐ Thyroid disorder_____

☐ Blood clots_____ ☐ Fibromyalgia_____ ☐ Psoriasis_____ ☐ Tuberculosis_____

☐ Cancer_____ ☐ Heart Disease_____

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 per day?_____

How many cigarettes per day?_____

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

Are you receiving disability? ☐ Yes ☐ No

Are you applying for disability? ☐ Yes ☐ No

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

Date of last mammogram_____/_____/_____

Date of last eye exam _____/_____/_____

Date of last chest x-ray _____/_____/_____

Date of last bone densitometry (DXA) _____/_____/_____

PAST MEDICAL HISTORY

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

☐ Anemia	☐ Fibromyalgia	☐ Leukemia
☐ Bad headaches	☐ Glaucoma	☐ Liver disease
☐ Blood clots	☐ Goiter	☐ Nervous breakdown
☐ Breathing problems	☐ Heartburn	☐ Psoriasis
☐ Cancer	☐ Heart problems	☐ Rheumatic Fever
☐ Cataracts	☐ High blood pressure	☐ Sleep apnea
☐ Colitis	☐ High cholesterol	☐ Stomach ulcers
☐ Depression/Anxiety	☐ HIV/AIDS	☐ Stroke
☐ Diabetes	☐ Jaundice	☐ Thyroid disorder
☐ Epilepsy	☐ Kidney disease	☐ Tuberculosis

Other significant illness (please list)_____

_____

_____

What is your form of birth control?_____

Do you drive? ☐ Yes ☐ No

What is your current living situation (circle one):

House/Duplex Apartment Assisted Living Nursing Home

Other_____

Date of last colonoscopy _____/_____/_____

Date of last dental exam _____/_____/_____

Date of last Tuberculosis test _____/_____/_____

Location?_____

Vaccinations: Influenza/Flu ☐ Yes ☐ No Date:_____ Shingles ☐ Yes ☐ No Date:_____

Pneumonia ☐ Yes ☐ No Date:_____ DTaP ☐ Yes ☐ No Date:_____

Patient's Name_____ Date_____ MD Initials_____

SYSTEMS REVIEW

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

Constitutional
- ☐ Fatigue
- ☐ Fever
- ☐ Recent weight gain Amount_____
- ☐ Recent weight loss Amount_____
- ☐ Weakness

Eyes
- ☐ Double or blurred vision
- ☐ Dry eyes
- ☐ Eye pain
- ☐ Eye redness
- ☐ Feels like something in eye
- ☐ Itchy eyes
- ☐ Loss of vision
- ☐ Vision changes
- ☐ Watery eyes

Ear-Nose-Mouth-Throat
- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Dry mouth
- ☐ Dry nose
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Runny nose
- ☐ Sinus trouble
- ☐ Sores in mouth or nose
- ☐ Sore tongue

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

Respiratory
- ☐ Cough
- ☐ Coughing of blood
- ☐ Difficulty in breathing at night
- ☐ Fluid around lung or pleurisy
- ☐ Pain with breathing
- ☐ Shortness of breath
- ☐ Snoring
- ☐ Swollen legs or feet
- ☐ Wheezing (asthma)

Gastrointestinal
- ☐ Black stools
- ☐ Blood in stools (or bright red)
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Jaundice
- ☐ Nausea
- ☐ Stomach pain
- ☐ Vomiting

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

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? _____

Have you ever taken estrogen? ☐ Yes ☐ No

If so, how long?_____

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Morning stiffness

Lasting how long?

_____Minutes _____ Hours
- ☐ Muscle tenderness
- ☐ Muscle weakness

List joints affected in the last 6 months:

_____

_____

_____

_____

_____

Integumentary (skin)
- ☐ Color changes of hands or feet in the cold
- ☐ Easy bruising
- ☐ Hair loss
- ☐ Hives
- ☐ Nodules/bumps
- ☐ Pigment changes to skin
- ☐ Psoriasis
- ☐ Rash
- ☐ Skin redness
- ☐ Skin tightness
- ☐ Sun sensitivity

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Loss of consciousness
- ☐ Memory loss
- ☐ Muscle spasms
- ☐ Night sweats
- ☐ Numbness or tingling
- ☐ Restless legs
- ☐ Sensitivity or pain of hands and/or feet

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

Endocrine
- ☐ Excessive thirst

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

If yes, When?_____

Allergic/Immunologic
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Patient's Name_____ Date_____ MD Initials_____

ALLERGIES (medications, latex, food, etc.)

Allergic to	Reaction
1.	
2.	
3.	
4.	
5.	
6.	
7.	

PRESENT MEDICATIONS (list any medications you are taking. Include such items as aspirin, laxatives, calcium and other 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.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

PAST MEDICATIONS (Please review this list of "rheumatology" 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	
Prednisone (Deltasone, Rayos) or Methylprednisolone (Medrol)		☐	☐	☐	
NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)					
Aspirin		☐	☐	☐	
Celecoxib (Celebrex)		☐	☐	☐	
Diclofenac (Voltaren, Voltaren Gel, Arthrotec, Flector Patch, Pennsaid, Zorvolex)		☐	☐	☐	
Diflunisal (Dolobid)		☐	☐	☐	
Etodolac (Lodine)		☐	☐	☐	
Fenoprofen (Nalfon)		☐	☐	☐	

Patient's Name_____ Date_____ MD Initials_____

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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

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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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Office Hours: Monday-Thursday 8am-4pm and Friday 8am-12pm

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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 arrive past your scheduled appointment time 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, Aetna and several other PPO organizations. However, we recommend you contact your 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.

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 Physicians Lab, LabCorp and Quest Diagnostics 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.

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

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

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.