Greenwich Medical, P.C.
PATIENT DEMOGRAPHICS FORM

PLEASE PRINT

PATIENT NAME_____
Last First Middle
ADDRESS_____
Number & Street Apt# City State Zip
HOME PHONE_____WORK_____CELL_____
E-MAIL ADDRESS_____

DATE OF BIRTH_____AGE____SOCIAL SEC #_____SEX____

MARITAL STATUS (circle one) SINGLE MARRIED DIVORCED WIDOWED
STUDENT? Y N If yes, part or full time. School_____

PERSON INSURED_____RELATIONSHIP TO PATIENT_____
ADDRESS OF INSURED_____
Number & Street Apt# City State Zip
SOCIAL SEC #_____ DOB_____ PHONE#_____

PERSON INSURED'S EMPLOYER & ADDRESS_____
_____

PRIMARY INSURANCE INFORMATION
(INFORMATION MUST BE COMPLETED)
INSURANCE_____

ID#_____

GROUP#_____

SECONDARY INSURANCE INFORMATION

INS_____

ID#_____

GROUP#_____

REASON FOR VISIT_____
VISIT ACCIDENT RELATED? YES NO If yes AUTO WORK OTHER_____

WHO IS YOUR PRIMARY CARE DOCTOR?_____
EMERGENCY CONTACT
NAME_____PHONE_____RELATIONSHIP_____

ASSIGNMENT & RELEASE: I hereby authorize my insurance benefits to be paid directly to Greenwich Medical and I am financially responsible for any non-covered services. I also authorize Greenwich Medical to release any information required in the processing of all my claims.

SIGNATURE_____**DATE**_____
(Guardian's signature if required by law.)

Greenwich Medical, P. C.

Arthritis, Lupus, Osteoporosis & related disorders

South Denver Rheumatology
9570 S. Kingston Court, Suite 220
Englewood, CO 80112

Ndudi O. Oparaeche, M.D.

Date of First Appointment: ____/____/____ (MONTH DAY YEAR) Birthplace: _____

Name: _____ (LAST FIRST MIDDLE INITIAL MAIDEN) Birthdate ____/____/____ (MONTH DAY YEAR)

Address: _____ (STREET APT. #) Age: _____ Sex: ____ F ____ M

_____ (CITY STATE ZIP) Telephone: Home ( ) _____

Work ( ) _____

Referred here by: (check one)

____ Self ____ Family ____ Friend ____ Doctor ____ Other Health Professional

Name of person making referral _____

The name of the physician providing your general medical care? _____

Do you have an orthopedic surgeon? ____ Yes ____ No. If yes, Name _____

Describe briefly your present symptoms:

_____

_____

_____

_____

Date symptoms began (approximate) _____ Diagnosis given? (Please list) _____

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: _____

_____

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
____	Arthritis (type unknown)	_____	____	Lupus or "SLE"	_____
____	Osteoarthritis	_____	____	Ankylosing spondylitis	_____
____	Rheumatoid Arthritis	_____	____	Childhood arthritis	_____
____	Gout	_____	____	Osteoporosis	_____

Other arthritis conditions: _____

SYSTEMS REVIEW

As you review the following list, please check any of those problems which apply to you.

GENERAL:
_____ Recent weight gain/Amount
_____ Recent loss of weight/Amount
_____ Fatigue
_____ Weakness
_____ Fever

NERVOUS SYSTEM:
_____ Headaches
_____ Dizziness
_____ Fainting
_____ Muscle spasm
_____ Loss of consciousness
_____ Sensitivity or pain of hands and/or feet
_____ Memory loss

EARS:
_____ Ringing in ears
_____ Loss of hearing

EYES:
_____ Pain
_____ Redness
_____ Loss of vision
_____ Double or blurred vision
_____ Dryness
_____ Feels like something in eye

NOSE:
_____ Nosebleeds
_____ Loss of smell
_____ Dryness

MOUTH:
_____ Sore tongue
_____ Bleeding gums
_____ Sores in mouth
_____ Loss of taste
_____ Dryness

THROAT:
_____ Frequent sore throats
_____ Hoarseness
_____ Difficulty in swallowing

Date of last eye examination_____
Date of last chest X-Ray_____
Date of last Tuberculosis Test _____

NECK:
_____ Swollen glands
_____ Tender glands

HEART AND LUNGS:
_____ Pain in chest
_____ Irregular heart beat
_____ Sudden changes in heart beat
_____ Shortness of breath
_____ Difficulty in breathing at night
_____ Swollen legs or feet
_____ High blood pressure
_____ Heart murmurs
_____ Cough
_____ Coughing of blood
_____ Wheezing
_____ Night sweats

STOMACH AND INTESTINES:
_____ Nausea
_____ Vomiting of blood or coffee ground material
_____ Stomach pain relieved by food or milk
_____ Yellow jaundice
_____ Increasing constipation
_____ Persistent diarrhea
_____ Blood in stools
_____ Black stools
_____ Heartburn

KIDNEY/URINE/BLADDER:
_____ Difficult urination
_____ Pain or burning on urination
_____ Blood in urine
_____ Cloudy, "smoky" urine
_____ Pus in urine
_____ Discharge from penis/vagina
_____ Frequent urination
_____ Getting up at night to pass urine
_____ Vaginal dryness
_____ Rash/ulcers
_____ Sexual difficulties
_____ Prostate trouble

BLOOD:
_____ Anemia
_____ Bleeding tendency

SKIN:
_____ Easy bruising
_____ Redness
_____ Rash
_____ Hives
_____ Sun sensitive (sun allergy)
_____ Tightness
_____ Nodules/bumps
_____ Hair loss
_____ Color changes of hands or feet in the cold

MUSCLES/JOINTS/BONES:
_____ Morning stiffness
Lasting how long
_____ Minutes
_____ Hours
_____ Joint pain
_____ Muscle weakness
_____ Muscle tenderness
_____ Joint swelling
List joints affected in the last 6 months:

_____
_____
_____
_____
_____
_____

HABITS:
Do you drink coffee? _____
Cups per day? _____
Do you smoke? ___ Yes ___ No ___ Past
Cigarettes per day? _____
Has anyone ever told you to cut down on your drinking? ____ Yes ____ No
Do you use drugs for reasons that are not medical? If so, please list:

_____
_____

How many pillows do you use to sleep on each night? _____
Do you get enough sleep at night?
Yes _____ No _____
Do you wake up feeling rested?
Yes _____ No _____

MENSTRUAL:
Age when periods began: _____ . Periods regular: _____ Yes _____ No. How many days apart: _____ . Date of last period: _____ .
Date of last Pap smear: _____ . Bleeding after menopause: _____ .

PAST PERSONAL HISTORY:

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

Cancer _____	Heart Problems _____	Asthma _____	Goiter _____
Leukemia _____	Stroke _____	Cataracts _____	Diabetes _____
Epilepsy _____	Nervous breakdown _____	Stomach ulcers _____	Rheumatic Fever _____
Bad Headaches _____	Jaundice _____	Colitis _____	Kidney Disease _____
Pneumonia _____	Psoriasis _____	Anemia _____	

Other Significant Illness (Please list) _____

Previous Operations:

	Type	*Year*	*Surgeon*	*City*
1)				
2)				
3)				
4)				
5)				
6)				
7)				

Any previous fractures? ☐ No ☐ Yes Describe _____

Any other serious injuries? ☐ No ☐ Yes Describe _____

FAMILY HISTORY:

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of Brothers _____ Number Living _____ Number Deceased _____

Number of Sisters _____ Number Living _____ Number Deceased _____

Number of children _____ Number Living _____ Number Deceased _____ List ages of each _____

Serious illnesses of children _____

_____

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

Cancer _____	Heart disease _____	Rheumatic fever _____	Tuberculosis _____
Leukemia _____	High Blood Pressure _____	Epilepsy _____	Diabetes _____
Stroke _____	Bleeding tendency _____	Asthma _____	Goiter _____
Colitis _____	Alcoholism _____		

MARITAL STATUS:

_____ Never Married _____ Married _____ Divorced _____ Separated

Spouse _____ Alive/Age _____ _____ Deceased/Age _____ Major Illnesses: _____

EDUCATION *(circle highest level attended)*

Grade School 1 2 3 4 5 6 Junior High School 7 8 9 High School 10 11 12 College 1 2 3 4 Graduate School

Occupation: _____ Number of hours worked/average per week _____

HOME CONDITIONS

Check one: ☐ House ☐ Apartment

Do you have stairs to climb? ☐ Yes ☐ No If yes, how many? _____

Number of people in household _____ Relationship, and age of each? _____

Who does most of the housework? _____ Who does most of the shopping? _____

On the scale below, circle a number which best describes your situation; Most of the time, I function . . .

1 VERY POORLY — 2 POORLY — 3 OK — 4 WELL — 5 VERY WELL

Because of health problems, do you have difficulty:
(Please check the appropriate response for each question)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)			
Walking?			
Climbing stairs?			
Descending stairs?			
Sitting down?			
Getting up from chair?			
Touching your feet while seated?			
Reaching behind your back?			
Reaching behind your head?			
Dressing yourself?			
Going to sleep?			
Staying asleep due to pain?			
Obtaining restful sleep?			
Bathing?			
Eating?			
Working?			
Getting along with other family members?			
In your sexual relationship?			
Engaging in leisure time activities?			
With morning stiffness?			
Do you use a cane, crutches, a walker, or a wheelchair? (circle item)			

What is the hardest thing for you to do? _____

Are you receiving disability? Yes _____ No _____

Are you applying for disability? Yes _____ No _____

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

MEDICATIONS

DRUG ALLERGIES: _____ No _____ Yes To What? _____

Type of reaction? _____

Present: (List any medications you are taking at this time. Include such items as aspirin, vitamins, laxatives, calcium supplements, etc.)

Name of Drug	Dose (Include strength and 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.					
11.					
12.					

Past: Please review this list of "arthritis" 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	Length of Time	Results A Lot	Some	Not At All	Reactions
1. Aspirin					
2. Aspirin-containing product					
3. Easprin					
4. Disalcid					
5. Tylenol (plain)					
6. Tylenol with codeine					
7. Darvon/Darvocet					
8. Clinoril					
9. Feldene					
10. Indocin					
11. Meclomen					
12. Motrin/Rufen					
13. Nalfon					
14. Naprosyn					
15. Tolectin					
16. Cortisone/Prednisone					
17. Benemid					
18. Colchicine					
19. Zyloprim/Lopurin					
20. Gold (Shots or Pills)					
21. Plaquenil					
22. Penicillamine					
23. Methotrexate					
24. Imuran					
25. Cytoxan					
26. Other					
27. Other					
28. Other					

Greenwich Medical, P.C.

Arthritis, Lupus, Osteoporosis & related disorders

Ndudi O. Oparaeche, MD

We are closed for lunch from 12:00 to 1:30 PM, phones are turned over at that time. The phone lines are open from 7:00 AM to 12:00 PM and 1:30 PM to 5:00 PM.

Parking is located in large parking areas directly across and around our office building. Reserved parking for disabled individuals is located close to the main lobby doors.

The following is a list of general office procedures and policies. Please feel free to ask about any questions or concerns you may have.

1) There is always a physician on call when our office is closed. Please use this service for non-life threatening emergencies to be referred to the appropriate facility for medical advice, treatment and follow-up. If you have a life threatening emergency, always call 911.
2) All patients are recommended to follow set protocols for their individual diagnosis (i.e. labs, x-rays and all other recommended procedures).
3) 24-hour notice is required for cancellation of an appointment. ***If an appointment is cancelled less than 24 hours in advance, a $25 fee will be assessed that is not billable to insurance.*** Extenuating circumstances will be taken into consideration. A $50.00 fee will be assessed for no call, no shows. This is the patient's responsibility, insurance will not be billed.
4) Our office operates by appointment only. ***If you arrive more than ten minutes late for your scheduled appointment time, you may be asked to reschedule.***
5) If you have ***more than 3 cancellations/missed/rescheduled appointments,*** it is at the Physician's discretion as to whether they will continue to see you.
6) Medication refills need to be phoned into your pharmacy ***48 hours*** in advance. Refills will be handled during office hours only. The on-call doctor will not refill medication.
7) It is the patient's responsibility to have a current referral or pre-certification for the services rendered at each visit. To avoid complications or misunderstandings, we ask that you arrange for a hard copy of the referral or a phone call from your primary care physician's office to be forwarded to our office prior to your visit.
8) ***Copays are due at the time of service. A $5 per month surcharge will be added for unpaid copays.***.
9) There will be a $25.00 fee assessed for all returned checks.

Sincerely,

Greenwich Medical, P.C.

Patient's Signature_____ Date_____

07/2012

Greenwich Medical, P.C.

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

1. I grant permission to Greenwich Medical, P.C. to disclose health information of the following individual as specified below:

Patient Name: _____

Preferred Name: _____

2. I authorize the information to be disclosed as specified below:

☐ On my voicemail/answering machine at home _____ (specify phone #)
☐ On my voicemail/answering machine at work _____ (specify phone #)
☐ On my voicemail on mobile phone _____ (specify phone #)

☐ To the following family member(s) or other person(s):

_____ / _____ / _____
Name Relationship Phone Number

_____ / _____ / _____
Name Relationship Phone Number

3. The type and amount of information to be disclosed is as follows:

Any information about the patient's treatment* OR:
☐ Laboratory results ☐ Medical instructions or advice
☐ X-Ray reports ☐ Prescription drug information

☐ Appointment information, including confirmation/cancellation of appointments

☐ Other (specify) _____

*I understand that this may include detailed personal medical information including medical services to be provided as well as any information listed in #3 above.

_____ _____ _____
Signature of Patient or Authorized Personal Representative (Please attach applicable legal documentation of authority) Print Name Date

This consent form will expire when revoked by the patient/representative.