SunValley Arthritis Center, Ltd.

6818 West Thunderbird Road
Peoria, AZ 85381
Phone: (623) 566-3550 / Fax: (623) 566-3573
Dr. Joy Schechtman & Dr. Jack Tuber
www.sunvalleyarthritiscenter.com

NEW PATIENT INFORMATION AND OFFICE POLICY

Dear: _____

Welcome to Sun Valley Arthritis Center! We are looking forward to working with you and coming up with a treatment plan so you can start feeling your best. Your new patient appointment is scheduled for:

_____

Please bring in the attached paperwork with you on your appointment day along with a photo ID, insurance card(s), list of medications you are taking (including over the counter), list of surgeries (if any) and your co-payment for appointment. Please also make sure that all records and referrals are in our office prior to your visit. (If they have already been sent to our office, please disregard)

Thank you, we are looking forward to meeting with you.

Your first initial visit you will be seeing a Nurse Practitioner (NP). Dr. Schechtman does come in to meet and speak with you briefly. Please note that if you have changes in **Insurance** and/or **Primary Care Physician (PCP)**, please let us know about this as soon as possible. All insurances and PCP **must be verified** prior to actually seeing the physicians on your first visit. Any new patient who does not have correct information or who does not arrive on time will be rescheduled to a later date or not rescheduled at all.

Please note that we have a **48-hour cancellation policy** for new appointments. Any change of date or cancellation must be called into the office 48 hours prior to your appointment. There will be a $55.00 fee if you fail to notify us within this 48-hour time period. All cancellations or reschedules are considered on an individual basis.

_____

New Patient Coordinator
Sun Valley Arthritis Center
6818 W. Thunderbird Rd.
Peoria, AZ 85381
Email: NewPatients@svacltd.com
Direct #: (623) 209-7848
Office #: (623) 566-3550 Ext 248
Fax #: (623) 566-3573

SunValley Arthritis Center, Ltd.

PATIENT INFORMATION SHEET

(Please print clearly and complete each section.)

Name: (Last):_____ (First): _____ (M.I.):_____

Date of Birth: _____ ☐Male ☐Female Social Security Number: _____

Address:(Street): _____

(City): _____, (State): _____ (Zip): _____

Phone:(Home):_____ (Cell): _____ (Work): _____ EXT:_____

E-Mail: _____

Occupation: _____Employer: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Domestic Partner ☐ Other

Title: ☐ Mr. ☐Mrs. ☐Ms. ☐Dr. Student? ☐ Full time? ☐ Part time? ☐

Preferred Language: ☐ English ☐ Spanish ☐ Dutch ☐ French ☐ Japanese ☐Other: _____

Race: ☐White ☐Black/African American ☐ American Indian/Alaska Native ☐ Hispanic ☐ Asian

☐Native Hawaiian/Other Pacific Islander ☐ Decline to specify ☐Other: _____

Emergency Contact:

Name: _____

Phone #: _____

Relationship to Patient: _____

Primary Care Physician (PCP)

Name(First): _____(Last): _____

Address:(Street): _____

(City): _____, (State): _____ (Zip): _____

Phone No: _____ Fax: _____

Pharmacy: _____ Location: _____

Phone No: _____ Fax: _____

PRIMARY INSURANCE

Provider: _____ ID #: _____ Group #: _____

Subscriber Name:(Last): _____ (First): _____(M.I.): _____

Address:(Street): _____

(City): _____, (State):_____ (Zip):_____

Phone:(Home):_____ (Cell):_____ (Work):_____ EXT:_____

Date of Birth: _____ ☐Male ☐Female Social Security Number: _____

Occupation: _____Employer: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

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SECONDARY INSURANCE

Provider: _____ID #: _____Group #: _____

Subscriber Name:(Last): _____(First): _____(M.I.): _____

Address:(Street):_____

(City):_____, (State):_____ (Zip):_____

Phone:(Home):_____ (Cell):_____ (Work):_____ EXT:_____

Date of Birth: _____ ☐Male ☐Female Social Security Number: _____

Occupation: _____Employer: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

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SunValley Arthritis Center, Ltd.

SUN VALLEY ARTHRITIS CENTER
OFFICE POLICY

PLEASE READ EACH PARAGRAPH BELOW AND INITIAL THAT YOU UNDERSTAND EACH PARAGRAPH

I will inform Sun Valley Arthritis Center, Ltd of any changes in my insurance coverage.	_____ Initials
I understand the billing process may take 4-6 weeks at which time my insurance will determine and pay for services per my contract.	_____ Initials
I understand that if my insurance requires an authorized referral for care at our practice, that it will secure this referral from my primary care physician/provider prior to my arrival at the office. My visit cannot begin until a referral is received	_____ Initials
I understand that it is my responsibility to pay all co-pays, deductibles, and estimated co-insurance amounts at the time service is rendered and any remaining balance as determined by my insurance company.	_____ Initials
I understand that Sun Valley Arthritis Center, Ltd may request proof of my insurance premium payment.	_____ Initials
I understand that if I fail to cancel without giving 24 hours notice or don't show up for a scheduled appointment on time I will be subject to a **$40.00 No Show/Late fee.** No shows for <u>new patient appointments and report visits</u> may be subject to a **$55.00 cancellation fee.** Exceptions for emergencies will be considered on an individual basis.	_____ Initials
I understand that all delinquent/past due accounts are subject to collection. In addition to the balance due, I will be responsible for the payment of all fees, including, but not limited to, collection, attorney and court fees. Checks returned for insufficient funds or closed account will be charged **<u>an additional $50.00 fee</u>** in addition to the amount of the check. Reimbursement must be made within 10 days of notification. If you have a check returned, we will no longer accept checks from you as a form of payment. Cash, Debit Card, or Credit Cards will be the only accepted forms of payment.	_____ Initials
I understand that <u>I will alternate</u> seeing Dr. Joy Schechtman and a Nurse Practitioner (NP) for all follow up office visits.	_____ Initials

With my signature:

1. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.
2. I request that payment of authorized benefits be made on my behalf. I assign the benefits to which I am entitled (including Medicare, private insurance and any other health plans) be made payable to Sun Valley Arthritis Center, Ltd.
3. I affirm, this assignment will remain in effect until revoked by me, in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance.
4. I affirm that I have read, and fully understand, the policies set forth on this document.
5. I affirm that the information I have provided on this form is accurate and true to the best of my knowledge.

Patient Signature: Date:

Signature of Parent/Guardian for Patient under the age of 18 Date:

Sun Valley Arthritis Center participates in a variety of medical research studies. Would you like more information about participating in our studies?

Yes: ☐

No: ☐

SunValley Arthritis Center, Ltd.

HIPAA RELEASE FORM:

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI) & CONTACT LIST

Patient Name: _____ **DOB**: _____ **Date**: _____

I authorize Sun Valley Arthritis Center, Ltd to use/disclose my personal health information to the individuals on this form _____ Initials

I understand that Sun Valley Arthritis Center, Ltd staff may leave a detailed message on my voicemail. _____ Initials

Contact name: _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Contact name: _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

- I hereby authorize Sun Valley Arthritis Center, Ltd to use and disclose my personal health information (PHI) to the individuals identified on this form.
- I understand this authorization does not expire unless written notice is mailed to 6818 W. Thunderbird Rd, Peoria, AZ 85381.
- I understand that this may include information relating to communicable diseases, such as HIV/AIDS, sexually transmitted diseases, behavioral or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist.
- I understand that the individuals identified on this form will be treated by Sun Valley Arthritis Center, Ltd as individuals involved directly in my care and as such, Sun Valley Arthritis Center, Ltd will be allowed to release my PHI to these individuals for the purpose of treatment, payment and healthcare operations.
- I have read and received a copy of the above statements and accept these terms. A duplicate of the statement is considered the same as the original. I voluntarily sign this authorization, and I understand that my ability to option health care from Sun Valley Arthritis Center, ltd will not be affected if I refuse to sign this authorization.

Health Information Exchange:

- I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the Health Information Exchange of Arizona, or I have previously received this information and decline another copy.

Patient Signature: _____ **Date:** _____

Personal Representative Signature: _____ **Date:** _____

Relationship to Patient: _____

SunValley Arthritis Center, Ltd.

Patient History Form

Date of first appointment: _____ Time of appointment: _____ Birthplace: _____

Name: _____ Birthdate: _____
LAST FIRST MIDDLE INITIAL MAIDEN

Address: _____ Age _____ Sex: ❑ F ❑ M
STREET APT#

_____ Telephone: Home: _____
CITY STATE ZIP Work: _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses: _____

EDUCATION *(circle highest level attended):*

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/Average per 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 primary medical care: _____

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)*:

_____

_____

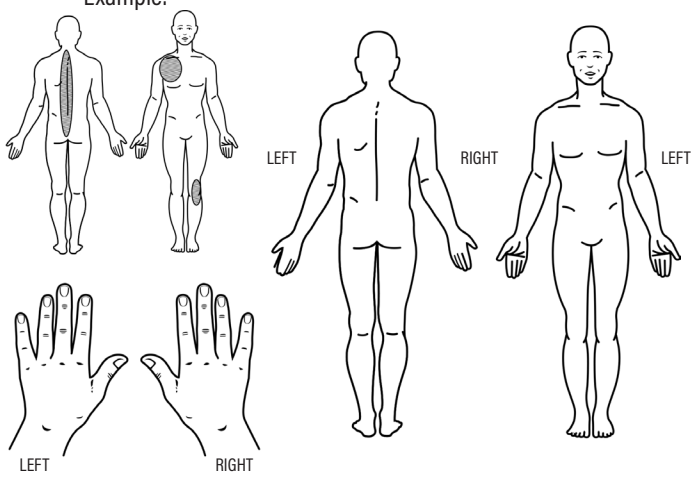
_____

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**.



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

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 (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Other arthritis conditions: _____

SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last mammogram: _____/_____/_____ Date of last eye exam: _____/_____/_____ Date of last chest x-ray: _____/_____/_____

Date of last Tuberculosis Test _____/_____/_____ Date of last bone densitometry _____/_____/_____

Constitutional

- ❑ Recent weight gain amount _____
- ❑ Recent weight loss amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Eyes
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears-Nose-Mouth-Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty swallowing

Cardiovascular

- ❑ Chest Pain
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary

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

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? _____

Musculoskeletal

- ❑ Morning stiffness
  Lasting how long?
  _____Minutes _____Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling
  List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

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

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric

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

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago?_____

Do you drink alcohol? ❑ Yes ❑ No Number per 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

PAST MEDICAL HISTORY

Do you now have or have you ever 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	❑ HIV/AIDS	❑ High Blood Pressure
❑ Emphysema	❑ Glaucoma	❑ Tuberculosis

Other significant illness *(please list)* _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

PREVIOUS SURGERIES

Type	Year	Reason
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 siblings_____ Number living _____ Number decreased _____

Number of siblings_____ Number living _____ Number decreased _____ List ages of each_____

Health of children_____

_____

Do you know 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 _____	❑ Psoriasis _____	

MEDICATIONS

Drug allergies: ❑ No ❑ Yes If yes, please list: _____

_____

Type of reaction: _____

PRESENT MEDICATIONS *(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)*

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 "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/Dose	Length of time	Please check: *Helped?*			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past Flurbiprofen Diclofenac + misoprostil Aspirin (including coated aspirin) Celecoxib Sulindac Oxaprozin Salsalate Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Choline magnesium trisalcylate Diclofenac					
Pain Relievers					
Acetaminophen		❑	❑	❑	
Codeine		❑	❑	❑	
Propoxyphene		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab		❑	❑	❑	
Golimumab		❑	❑	❑	
Hydroxychloroquine		❑	❑	❑	
Penicillamine		❑	❑	❑	
Methotrexate		❑	❑	❑	
Azathioprine		❑	❑	❑	
Sulfasalazine		❑	❑	❑	
Quinacrine		❑	❑	❑	
Cyclophosphamide		❑	❑	❑	
Cyclosporine A		❑	❑	❑	
Etanercept		❑	❑	❑	
Infliximab		❑	❑	❑	
Tocilizumab		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: *Helped?*			Reactions
		A Lot	Some	Not At All	
Osteoporosis Medications					
Estrogen		❑	❑	❑	
Alendronate		❑	❑	❑	
Etidronate		❑	❑	❑	
Raloxifene		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal		❑	❑	❑	
Risedronate		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen		❑	❑	❑	
Tiludronate		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyaluronan		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	

Please list supplements:

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list:

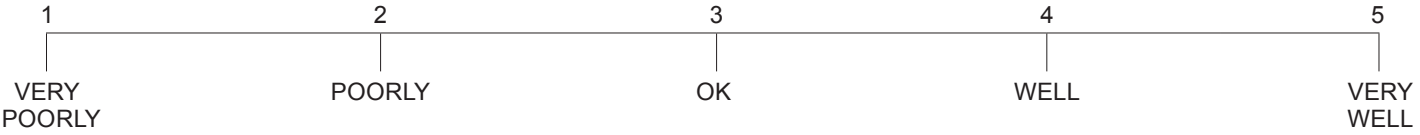
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No *If yes, how many?*

How many people in household? _____ Relationship and age of each _____

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

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



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 family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness	❑	❑	❑
Do you use a cane, crutches, walker or wheelchair? *(circle one)*	❑	❑	❑

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 ❑

DIRECTIONS TO OUR OFFICE

We are slightly west of 67th Ave on the North side of Thunderbird Road.

Traveling towards the west on Thunderbird Road, after you cross 67th Ave, turn right as if going into MasterTech Auto. We are the building behind MasterTech.

If you are traveling east (ie. coming from 101) after you pass Heritage Funeral you will turn left (northside) as if going to MasterTech Auto. We are the building directly behind this.

If you are traveling south on 67th Ave you can also turn in at Sonic. Come thru the medical complex and reach the small turn-in "street' and then reach Our Building – SunValley Arthritis Center.

Look for our name in orange lettering up on our building "Sun Valley Arthritis Center".