THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

UT RHEUMATOLOGY
A Department of the University of Tennessee Medical Center
1932 Alcoa Hwy
Medical Building C, Suite 550
Knoxville, TN 37920
865-305-6543 (Phone) | 865-305-2694 (Fax)
UTRheumatology@utmck.edu

PATIENT REGISTRATION

Date	For Internal Use Only	Patient Number

PATIENT INFORMATION

Social Security #		Date of Birth	
First Name	Middle	Last Name	
Home Address	City	State	Zip
Email Address			
Race	Ethnicity	Preferred Language	
Gender (Circle as many as are appropriate) Birth Sex: Male Female Transgender Other Current Sex: Male Female Transgender Other			
Marital Status (Circle One) Married Single Divorced Widowed		Home Phone ( ) Cell Phone ( )	
(Circle One) Employed Retired Disabled F/T Student Other		Employer Work Phone ( )	
Referring Physician	Primary Care Physician		
How did you hear of us?			

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Insurance	ID #	GR #
Name of Insured	DOB	SS#

SECONDARY INSURANCE INFORMATION

Insurance	ID#	GR #
Name of the Insured	DOB	SS#

EMERGENCY CONTACT

Relationship		
First Name	Middle	Last
Home Phone ( )	Work Phone ( )	Cell ( )

SPOUSE/GUARANTOR/RESPONSIBLE PARTY

Social Security #		Sex	Date Of Birth
Relationship		Daytime Phone ( )	
First Name	Middle	Last Name	
Address		City	State Zip
Employer	Address		
City	State	Zip	

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE (Patient or Parent if Minor)	DATE

PLEASE SEE OTHER SIDE FOR MORE INFORMATION → → →

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PATIENT PRIVACY QUESTIONNAIRE

Patient Name:_____

1. May we leave confidential messages regarding appointments, return calls for test results, etc. on your home answering machine or voice mail?

   Yes No

   If yes, please list in order of preference where we are able to leave confidential messages regarding appointments, return calls for test results, etc.

   Phone Number: _____ Home Mobile Work
   Phone Number: _____ Home Mobile Work
   Phone Number: _____ Home Mobile Work

2. If we are unable to reach you by any of the above options, may we leave confidential messages at your place of employment?

   Yes No

   If yes, please provide place of employment and individuals we are able to leave confidential messages with.

   Employer:_____ Individual(s):_____
   Relationship:_____ Phone Number:_____

3. May we give confidential information to individuals you designate regarding appointments, lab results or other healthcare information?

   Yes No

   If yes, please list individual(s) below:

   Name:_____ DOB:_____
   Relationship:_____ Phone Number:_____
   Name:_____ DOB:_____
   Relationship:_____ Phone Number:_____

If we are unable to reach you by any other means, we will send information through the US Postal Service to your home address.

_____ _____
Signature of patient (or guardian if under age 18) Date

I have received a copy of the University Physician Associations Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by UPA, physicians and other providers practicing at UPA facilities and that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by call (865) 544-9118, by visiting www.utmedicalcenter.org or by requesting one at a UPA office.

_____ _____
Signature of patient (or guardian if under age 18) Date

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POLICIES AND PROCEDURES

1. **BILLING:** We would like to take this opportunity to explain the way your visit to UT Rheumatology will be billed to your insurance company. We are an outpatient department of UT Medical Center. As an outpatient department, you will receive a facility charge from the hospital. We are not billed like a visit to your regular doctor/specialist office. This method of billing is customary with hospital-based clinics and other areas here at the hospital. You will also receive a charge from your physician for the office visit. You may receive a bill from Lab Corp for any lab testing completed. If you have any questions regarding your bill, please call: 865-251-4400 for UT Medical Center billing and/or 865-670-6199 for physician office billing.

2. **COPAYMENTS, COINSURANCES, OR DEDUCTIBLES:** Co-payments will be collected at time of service. All of these payments are expected to be paid in full on the date of service as required by your insurance company.

3. **ARRIVALS:** Return patients who arrive more than 15 minutes after their scheduled appointment time may be asked to reschedule. Return patients may be given the option to wait for another appointment time on the same day if one is available. New patients are expected to arrive 30 minutes prior to scheduled appointment time bringing with them their completed paperwork, their insurance card, and a photo ID. New patients may be asked to reschedule if the arrival time is later than the appointment time or if new patient paperwork is not completed upon arrival.

4. **NO SHOW APPOINTMENTS: CANCELLATIONS AND RESCHEDULES:** We require at least 24 hour notice if you will be unable to keep your appointment. If you do not show for any appointment three times without calling to cancel or reschedule your appointment, you may be dismissed from the practice. A new patient who fails to show for their new patient appointment may be dismissed from the practice as well.

5. **APPOINTMENTS:** Once care has been established with a provider within our office, our office policy prohibits patients from switching to a different provider in the same office.

6. **PARKING:** Parking can be challenging on the UT medical center campus, and we encourage you to allot ample time for parking. Our office does not offer parking vouchers. Standard parking rates are $3.00 and valet parking is $5.00.

7. **NON-INSURED PATIENTS:** Our patients will need to be prepared to pay the balance in full at check out. A discount of 60% will be given to self-pay patients paying at the time of service. All other self-pay patients will need to call our Billing Office at 865-670-6199 to make payment arrangements.

8. **REFERRALS:** If your insurance requires a referral or authorization from your PCP to see our providers, it is important that you obtain this before coming to your appointment. The referrals and authorizations may be faxed to our office at 865-305-2694.

9. **NON-COVERED SERVICES:** Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by your insurance, even though your physician may feel that it is necessary. Our office will file each visit with your insurance company. If they deem that something is not reasonable or necessary, you will be responsible for this cost.

10. **PROOF OF INSURANCE:** All patients must complete our patient information form before seeing our physician. We will ask that you complete this form once every year. We will need copies of your current insurance and pharmacy cards to provide proof of coverage. If you fail to provide us with the correct information in a timely manner, you will be responsible for the balance of the claim. If your insurance changes, please notify us immediately so we can make the changes to allow you to receive maximum benefits from your policy. We will need a copy of your new insurance card at your next visit. We will need a copy of your new insurance card prior to refilling any medications. Your pharmacy card will allow you to receive full benefits in the event a specialty drug is prescribed.

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POLICIES AND PROCEDURES

11. **CLAIM SUBMISSION:** We will submit your claims and assist you in any way reasonably possible to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance policy is a contract between you and your insurance company. If your insurance company does not pay your claim in 45 days after being filed. The balance will automatically be billed to you. If you have Medicare, we will bill any monies owed after we have received payment from Medicare and/or secondary policy that you might have.

12. **NON-PAYMENT:** If your account is over 90 days past due, you will receive a letter from our billing department. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency, and you may be dismissed from our practice.

13. **HIPAA:** A copy of the UPA Notice of Information Practice has been made available to me. I understand that this notice describes how my health information may be used or disclosed by UPA, physicians and other providers practicing at UPA facilities and I that I should read it carefully. I am aware that the notice may be changed at any time. I may obtain a revised copy of the notice by calling 865-305-9118, by visiting www.utmedicalcenter.org or by requesting one from the UPA office.

14. **MEDICAL RECORDS AND COMPLETING FORMS:** Medical records will be sent to any physician upon completion of a medical release form. Attorneys requesting medical records are charged $20 for the first 40 pages, and 25 cents per page after 40. Please be advised that all forms will be completed for a charge of $25 which is due upon receiving forms. Please allow 7-10 business days for any forms and medical records request to be completed.

15. **ROUTINE PRESCRIPTION REFILLS:** The safest and most effective way to obtain prescription refills is to call your pharmacy and ask them to fax a request to our office. Your pharmacy has an electronic record of your prescription history with the correct dosage and spelling of your medication. By your pharmacy sending the request, it ensures that we get the correct information and expedites our ability to approve your refill. Please allow 72 hours for refills to be processed. In addition, please request your refills a few days prior to being out of your medication.

16. **TEST RESULTS:** You are encouraged to join the IQHealth portal to see all results and communicate with our office. Please check with the front desk for instruction on joining this great communication tool. Occasionally, a test will be sent out to any outside laboratory and will take longer to receive those results. Please do not call the office regarding test results until 10 days after the test was performed. Please understand when calling our nurse line for any reason after 3:00 PM, your call will not be returned until the next business day that your provider is in the office. Calling and leaving multiple messages **will not expedite your request**. In fact, it may delay the response time, depending on the reason for the call.

I have read and understand the financial policies along with the prescription refill and test result policies.

Patient Signature: _____ Date: _____

A copy of this document can be provided to you upon request.

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NEW PATIENT HISTORY FORM

Date: _____ Birthplace: _____

Name: _____
Last First MI Maiden

Birthdate: _____ Age: _____ Sex: Female ☐ Male ☐

_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address:_____

_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated/Widowed

Spouse/Significant Other: Alive/Age_____

Deceased/Age_____ Major Illness_____

Education: Check highest level attended.

Grade School: __7 __8 __9 __10 __11 __12

College: __1 __2 __3 __4 Graduate School: _____

Occupation: _____ Average No. Hours worked/per week_____

Referred here by (check one): Retired (date retired):_____

☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of person making referral: _____

Name of physician providing your primary medical care: _____

Have you seen a rheumatologist? No___ Yes ___ If yes, when?: _____

Rheumatologist name:_____

Describe briefly your present symptoms: _____

_____

_____

Date Symptoms began (approximate):_____

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery, injections; list medications later):

_____

_____

Do you have an orthopedic surgeon? No___ Yes ___ If yes, name: _____

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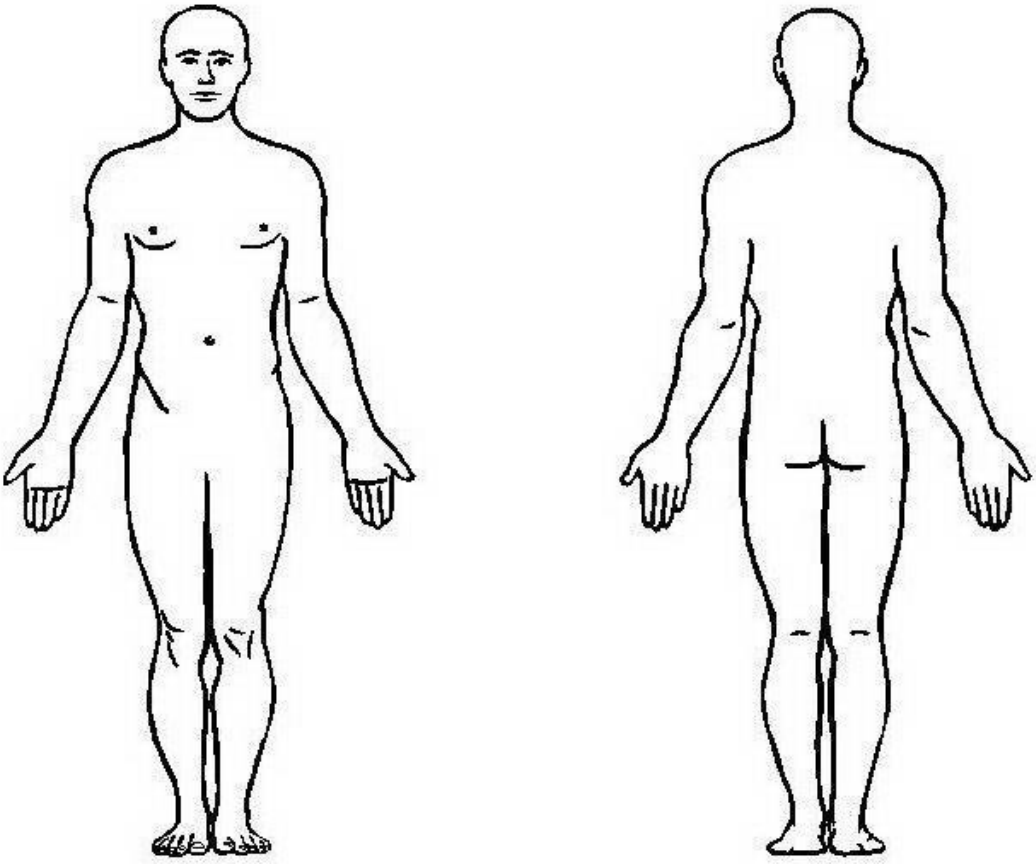
Please list the names of other practitioners you have seen for this problem:_____

_____

Please place an "X" on all the locations of your pain over the past week by marking on the appropriate areas on the body figures and hands below:



LEFT RIGHT

Patient's Name: _____ Date:_____

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NEW PATIENT HISTORY FORM

Systems Review

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

Constitutional	**Gastrointestinal**	**Integumentary (skin, and/or breast)**
☐ Recent weight gain	☐ Nausea	☐ Easy bruising
Amount_____	☐ Vomiting of blood or coffee ground material	☐ Redness
☐ Recent weight loss		☐ Rash
Amount_____	☐ Stomach pain relieved by food or milk	☐ Hives
☐ Fatigue		☐ Sun sensitive (sun allergy)
☐ Weakness	☐ Jaundice	☐ Tightness
☐ Fever	☐ Increasing constipation	☐ Nodules/bumps
Eyes	☐ Persistent diarrhea	☐ Hair loss
☐ Pain	☐ Blood in stools	☐ Color changes of hands or feet in the cold
☐ Redness	☐ Black stools	
☐ Loss of vision	☐ Heartburn	**Neurologic System**
☐ Double or blurred vision	**Genitourinary**	☐ Headaches
☐ Dryness	☐ Difficult urination	☐ Dizziness
☐ Feels like something in eye	☐ Pain or burning on urination	☐ Fainting
☐ Itching eyes	☐ Blood in urine	☐ Muscle spasm
Ears-Nose-Mouth-Throat	☐ Cloudy, "smoky" urine	☐ Loss of consciousness
☐ Ringing in ears	☐ Pus in urine	☐ Sensitivity/pain of hands or feet
☐ Loss of hearing	☐ Getting up at night to pass urine	☐ Memory loss
☐ Nose bleeds	☐ Discharge from vagina/penis	☐ Night sweats
☐ Loss of smell	☐ Genital Rash/ulcers	**Psychiatric**
☐ Dryness of nose	☐ Sexual difficulties	☐ Excessive worries
☐ Runny nose	*For Women Only*	☐ Anxiety
☐ Sore tongue	Age when periods began:	☐ Easily losing temper
☐ Bleeding gums	Periods regular? __Yes __ No	☐ Depression
☐ Sores in mouth	How many days apart?	☐ Agitation
☐ Loss of taste	Date of last period:	☐ Difficulty falling asleep
☐ Dryness of mouth	Date of last PAP:	☐ Difficulty staying asleep
☐ Frequent sore throats	Bleeding after menopause: __Yes __No	**Endocrine**
☐ Hoarseness	Number of pregnancies?	☐ Excessive thirst
☐ Difficulty in swallowing	Number of miscarriages?	**Hematological/Lymphatic**
☐ Excess dental cavities	*For Men Only*	☐ Swollen or tender glands
Cardiovascular	☐ Prostate trouble	☐ Anemia
☐ Pain in chest	**Musculoskeletal**	☐ Bleeding tendency
☐ Irregular heart beat	☐ Morning stiffness	☐ Clotting tendency
☐ Sudden changes in heart beat	Lasting how long?	☐ Transfusion, when_____
☐ High blood pressure	_____ Minutes _____ Hours	**Allergic/Immunologic**
☐ Heart murmurs	☐ Joint Pain	☐ Frequent sneezing
Respiratory	☐ Muscle weakness	☐ Increased susceptibility to infection
☐ Shortness of breath	☐ Muscle tenderness	
☐ Difficulty breathing at night	☐ Joint swelling	☐ Frequent sinus congestion
☐ Swollen legs or feet	List joints affected in the last 6 months:	
☐ Cough		
☐ Coughing of blood		
☐ Wheezing (asthma)		

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NEW PATIENT HISTORY FORM

Past Medical History

Do you now 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
☐ Hepatitis	☐ Osteoarthritis	☐ Childhood arthritis
☐ Rheumatoid Arthritis	☐ Gout	☐ Lupus or SLE
☐ Psoriatic Arthritis	☐ Ankylosing Spondylitis	☐ Osteoporosis

Arthritis conditions:

Other significant illness (please list):

_____

Non-pharmacologic, Natural, or Alternative Therapies:

☐ chiropractic	☐ hypnosis	☐ Other:_____
☐ acupuncture	☐ massage	_____
☐ physical Therapy	☐ occupational Therapy	_____

Past Surgical History (Operations)

Type	Year	Reason

Any previous **fractures**? ___ No ___ Yes
Describe:

Any other **serious injuries**? ___ No ___ Yes
Describe:

Health Maintenance

Please state the date of your last:

Mammogram:	Eye exam:
Chest x-ray:	Tuberculosis test:
Bone Densitometry (DEXA):	Flu Vaccine:
Pneumococcal Vaccine:	Tetanus Vaccine:
Prevnar Vaccine:	Hepatitis B Vaccine:
Shingles Vaccine:	

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NEW PATIENT HISTORY FORM

Rheumatologic Family History

At any time have your blood relative had any of the following? (check, indicate relationship)

	Relative (relationship)		Relative (relationship)
Arthritis (unknown type)		Lupus	
Osteoarthritis		Rheumatoid arthritis	
Gout		Ankylosing Spondylitis	
Childhood arthritis		Osteoporosis	

Family History

	If Living		If Deceased	
	Age	Health	Age at death	Cause
Father				
Mother				
Brothers/Sisters:	Age	Sex		
Sons/Daughters:	Age(s)			

Do you know of any blood relative who has had: (Check & Give Relationship, paternal/maternal)

☐ Cancer	☐ High blood pressure	☐ Asthma
☐ Leukemia	☐ Bleeding tendency	☐ Psoriasis
☐ Stroke	☐ Alcoholism	☐ Tuberculosis
☐ Colitis	☐ Rheumatic Fever	☐ Diabetes
☐ Heart disease	☐ Epilepsy	☐ Goiter
☐ Arrhythmia	☐ Clotting disorder	☐ Hypothyroidism

Social History

Do you drink **caffeinated beverages**? ___Yes ___No
If yes, cups/glasses per day? _____

Do you **smoke**? ___Yes ___ No ___ Past: How long ago? _____ How much? _____
Have you had attempts to quit? ___Yes ___ No When, how long?_____

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 List:

Exercise: Do you exercise regularly? ___ Yes ___ No Amount per week: _____
Type of exercise:

Sleep: How many hours of sleep do you get at night? _____hours
Do you get enough sleep at night? ___ Yes ___ No

Hobbies/recreation (optional): _____
Anything you would like to be able to do? _____

Diet (optional): Any restrictions? _____
How would you describe your diet? _____

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NEW PATIENT HISTORY FORM

Allergies (Please list any and all allergies below)

Present Medications
(List any medications you are taking, including 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

Past Medications

Non-Steroidal Anti-inflammatory Drugs (NSAIDs)
Please review this list of NSAIDS below and circle the ones you have taken in the past:

Ansaid (flurbiprofen)	Oruvail (ketoprofen)	Tolectin (tolmetin)
Arthrotec (diclofenac+misoprostil)	Lodine (etodolac)	Trilisate (choline magnesium tricalicylate)
Aspirin	Meclomen (meclofenamate)	
Celebrex (celecoxib)	Mobic (meloxicam)	Voltaren (diclofenac)
Daypro (oxaprozin)	Motrin, Advil (ibuprofen)	Pensaid (mefanamic acid)
Disalcid (salsalate)	Nalfon (fenoprofen)	Dolobid (diflunisal)
Feldene (piroxicam)	Naprosyn, Alleve (naproxen)	Bextra (valdecoxib)
Indocin (indomethacin)	Relefen (nabumetone)	Vioxx (rofecoxib)

Corticosteroids/prednisone/Medrol: drug name:_____ length of time: _____
Helped? ___A Lot ___Some ___Not at all
Reactions?

Herbal or Nutritional Supplements: (Please List)

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NEW PATIENT HISTORY FORM

Activities of Daily Living

Home Conditions:

Do you have stairs to climb? No___ Yes ___ If yes, how many? _____

How many people in household? _____

Relationship	Age

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

On the scale below, check the box which best describes your situation: *Most of the time, I function….*

☐	☐	☐	☐	☐
Very poorly	Poorly	Ok	Well	Very well
1	2	3	4	5

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?			
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 ☐ wheelchair

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 medically related lawsuit pending? ☐ Yes ☐ No