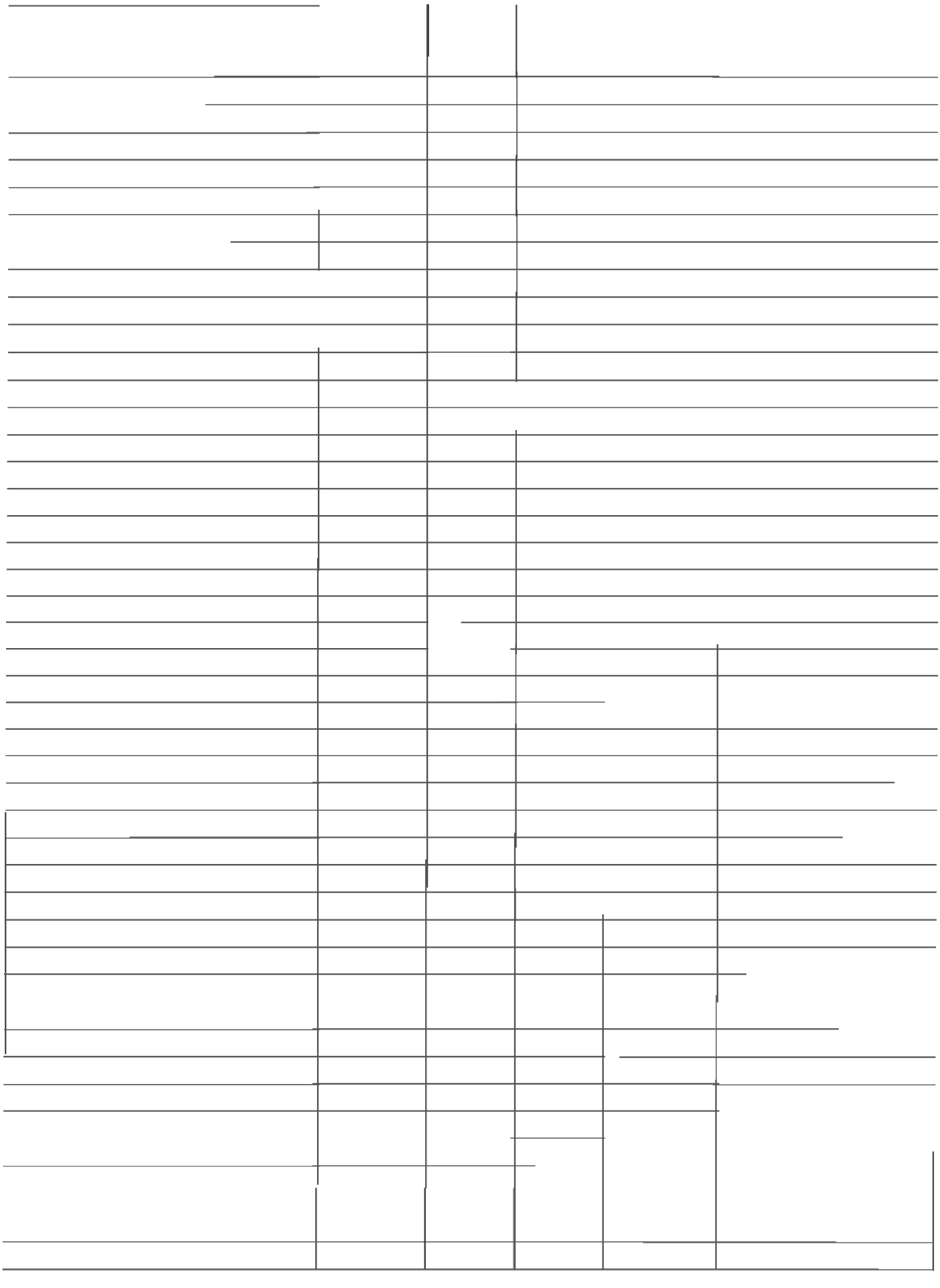


Drug names/Dose	Length of time	Helped A lot	Helped Some	Helped Not At All	Reactions
IVIG					
Privigen					
Gammagard					
Gammar - IV					
Gamimune - N					
Iveegam					
Polygam S/D					
Sandoglobulin					
Venoglobulin - I					
Venoglobulin - S					
Carimune - Panglobulin					
Gamunex					
Kiovig					
Gout					
Krystexxa (pegloticase)					
Lupus					
Benlysta (belimumab)					

Please list supplements:

_____

_____

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

If yes, please list

_____

_____

_____

_____

_____

_____

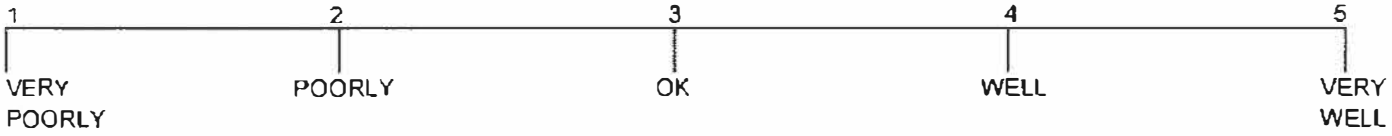
ACTIVITIES OF DAILY LIVING

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, as walker or a 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 ■

Patient's Name _____ Date _____ Physician Initials _____

Arthritis & Rheumatology Associates of South Jersey

Last Name _____ Date of Birth _____
First Name _____ MI _____ Gender: Male ____ Female ____
Mailing Address _____ Marital Status _____
_____ Social Security # _____
City, State, ZIP _____ Employer Name _____
Home Phone _____ Title _____
Work Phone _____ Ext. _____ Employment Status _____
Cell Phone _____ (FT, PT, retired, unemployed, disabled)
Email address _____ Student Status (FT, PT) _____

Additional Information

Name of Pharmacy _____ Pharmacy Phone # _____
Location of Pharmacy _____

Responsible Party

Last Name _____
First Name _____ MI _____
Date of Birth _____
Social Security # _____
Gender: Male ____ Female ____
Relation _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email address _____

Emergency Contact: [redacted]

Last Name _____
First Name _____ MI _____
Relation _____
Address _____
_____
City, State, ZIP _____
Home Phone _____
Work Phone _____ Ext. _____
Cell Phone _____
Email address _____

Insurance

Primary Insurance _____
Insurance Address _____
_____
City, State, Zip _____
Phone Number _____
Subscriber/Member # _____
Group Number _____
Co-pay Amount _____
Insured Name _____
Insured's SSN _____
Insured's DOB _____
Relationship _____

Secondary Insurance _____
Insurance Address _____
_____
City, State, Zip _____
Phone Number _____
Subscriber/Member # _____
Group Number _____
Co-pay Amount _____
Insured Name _____
Insured's SSN _____
Insured's DOB _____
Relationship _____

Arthritis & Rheumatology Associates of SJ, P.C.

2848 S. Delsea Drive, Ste. 2C, Vineland, NJ 08360
Phone: (856) 794-9090 Fax: (856) 794-3058

Name: _____ DOB: _____

Phone number: (_____) _____ - _____

_____ I acknowledge that I have received a copy of *"Notice of Privacy Practices"* & office policies from Arthritis & Rheumatology Assoc. of SJ

I hereby grant my permission for disclosure of my personal health information to:

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

Check Choice below:

___ I hereby give my permission for Arthritis & Rheumatology Assoc. of SJ staff to leave information on my answering machine/voice mail in reference to appointments & and medical instructions.

___I refuse disclosure of my personal health information to anyone other than myself.

Do you have a Living Will or Advanced Directive? Yes: ____ No: ____

Arthritis & Rheumatology Assoc. of SJ photographs patients and places the photo inside of the patient's chart. We do this to help to document medical conditions, prevent medical errors and identity theft.

Do you consent to be photographed? Yes: ____ No: ____

Do you have a language, cultural and/or religious custom which may impact our provider's ability to provide medical care?

What type? ☐ Language ☐ Cultural Custom ☐ Religious Custom ☐ None

Note: **All co-pays are due at the time of service. A $30 fee may be assessed for "no-show" appointments. All balances are due in 30 days unless special arrangements are made. We do not routinely call for delinquent acconnts. Accounts that are greater than 90 days past due are sent for collections unless payment arrangements have been made and are current. You will be responsible for any balances due to lack of coverage and pre-existing conditions not covered under your plan.**

Patient/Guarantor Signature: _____ Date: _____

Arthritis & Rheumatology Associates of South Jersey
Financial Policy

Your complete understanding of your financial responsibility is essential. Your insurance is a contract between you, your employer and the insurance company. **We are not part of that contract.**

Appointment Cancellations: Please notify our office of any appointment cancellations at least 24 hours in advance by calling the office or the answering service. We reserve the right to charge you (not your insurance company) for a missed appointment. This is a $35.00 fee (fee amount is subject to change without prior notice).

Laboratory, Radiology and other diagnostic service bills: Please check with your insurance company to verify what your insurance benefits allow for. The doctor may order tests during your visit. These services are billed separately by the laboratory or diagnostic facility that performs these tests and are not covered by payments that you make to us.

Medical Record Fees: There will be a fee for copying medical records of $1.00 per page up to $100.00. There is an additional search fee of $10.00 and postage fees. You must fill out a medical records request form to obtain a copy of your medical records. Please allow up to 30 days for processing of your copy of medical records.

Payment Responsibility: I hereby authorize payment directly to **Artbritis & Rheumatology Associates of South Jersey, P.C.** of the physician's attendance benefits otherwise payable to me but not to exceed the charges as stated. I understand that I am financially responsible to **Arthritis & Rheumatology Associates of South Jersey, P.C.** for the charges not covered by this authorization. I also understand and agree that if my account is delinquent and incurs collections fees or legal fees that I am responsible for payment of those fees as well as the full balance of my account.

I have read and fully understand the financial policy set forth by Arthritis & Rheumatology Associates of South Jersey, P.C. I understand and agree to the terms of this policy. I also understand and agree that the terms of this financial policy may be amended by Arthritis & Rheumatology Associates of South Jersey, P.C. at any time without prior notification to me.

Signature of patient or responsible party	Date
Printed name of patient or responsible party	Date
Office Employee	Date

Arthritis & Rheumatology Associates of South Jersey, P.C.
2848 S. Delsea Drive, Ste 2C
Vineland, NJ 08360
856-794-9090

Form Effective: October 17, 2014