Patient History Form

Date of first appointment: ____/____/____ Time of appointment: _____ Birthplace: _____
month day year

Name: _____ Birthdate: ____/____/____
last first middle initial maiden month day year

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: _____

Email: _____

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: _____

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: _____

Social History

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 exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of sisters _____ Number living _____ Number decreased _____

Number of brothers _____ Number living _____ Number decreased _____ List ages of each _____

Health of children _____

PAST MEDICAL HISTORY

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

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:* _____

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?* A Lot	Some	Not At All	Reactions
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:		❑	❑	❑	
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		❑	❑	❑	

Kathy Karamlou, M.D., Inc.

Rheumatology
361 Hospital Rd, #428
Newport Beach, CA 92663

Patient Information: **Birth Date:**_____

Last Name: _____ First: _____ Middle: _____

Address: _____ City: _____ Zip Code:_____

Telephone #: _____ Cell Phone #:_____ Social Security #: _____

Drivers License #: _____ Circle: Male / Female Marital Status: M / D / S / W

Referred By: **NPI Number:**

Employment Information:

Occupation: _____ Employed By: _____

Address: _____ City: _____ Zip Code: _____

Telephone #: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____ City: _____ Zip Code: _____

Telephone #: _____

Insurance Information:

Primary Insurance Carrier:

Address: _____ City: _____ State: _____ Zip Code: _____

Insured's Name: _____ Birthdate: _____ Social Security #: _____

Relationship to Patient: _____ Insured's Employer: _____

Insured's Group #: _____ ID #:_____ Policy #:_____

Effective Dates of Policy: From: _____ To:_____ Phone # _____

Secondary Insurance Carrier:

Address: _____ City: _____ State: _____ Zip Code: _____

Insured's Name: _____ Birthdate: _____ Social Security #: _____

Relationship to Patient: _____ Insured's Employer: _____

Insured's Group #: _____ ID #:_____ Policy #:_____

Effective Dates of Policy: From: _____ To:_____ Phone # _____

ALLERGIES:

Assignment of Benefits/Financial Agreement:

I hereby give authorization for payment of insurance benefits to be made directly to Kathy Karamlou, M.D., Inc. for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance company. (Medicare patients are subject to Medicare's policies and regulations.) I hereby authorize this healthcare provider to release all information necessary to my insurance company(s) to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature:_____ **Date:** _____

NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of:
Kathy Karamlou, M.D.

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at 949-631-6500.

I acknowledge receipt of the ***Notice of Privacy Practices*** of:
Kathy Karamlou, M.D.

Signature: _____ Date: _____
(parent/patient/conservator/guardian)

I _____ authorize _____ to access my medical records.
(Print Patient Name) (Print Name)

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

_____

_____

Kathy Karamlou, M.D., Inc.

Patient Acceptance of Financial Responsibility

The practice of Kathy Karamlou, M.D., Inc. will bill your insurance company as a courtesy. However, you are ultimately responsible for all charges for services rendered. In the event services rendered are not covered by your insurance company, we will require that you remit payment to Kathy Karamlou, M.D., Inc. Additionally, if your insurance company does not remit payment in a timely manner (within 60 days from the time your claim is billed), we will transfer the balance to your responsibility and require that you remit payment to Kathy Karamlou, M.D., Inc. for all outstanding insurance balances over 60 days. The outstanding balances may include, but are not limited to:

- Office visit co-payments
- Annual deductibles
- Services that are not covered by your health plan
- Administrative charges for co-pays not paid at the time of service
- Interest charges for overdue patient due balances

In addition, your insurance company may require an authorization or pre-certification for certain procedures, services, drugs and supplies that will be provided to you. As a courtesy, we will contact your insurance company for authorization for services. However, it is ultimately your responsibility to understand what your insurance policy covers and assure that you have authorization for services. We may request your assistance in following up on our authorization requests and delayed payments. Your assistance in contacting your insurance company will often facilitate a more timely approval of services, prevent delays in treatment, and expedite payment for your services.

We frequently experience difficulty with insurance plans in receiving timely payment. Our policy is that we will bill your primary and secondary policies. If we do not receive payment within 60 days of the date we bill your insurance, then we will transfer the balance to your responsibility and require that you remit payment to Kathy Karamlou, M.D., Inc. To prevent this, we suggest that you stay in communication with your insurance company to assure they are paying for the services we render. Often, insurance companies are more responsive when they are contacted by their policyholders. In addition, should our billing office contact you for assistance in obtaining payment from your insurance company, your prompt response to their calls will also assist. They may be reached at 714-258-0011 and are there to assist you in obtaining payment on your claims.

We require timely payment when you receive your monthly statements. Balances are due upon receipt of your statement. Please provide the credit card information you would like to use for payment of your balance if you do not pay by cash or check. You will be notified in advance of charges made to your credit card.

Credit Card Type: Mastercard/Visa/Other [redacted]

Expiration Da[redacted] Name on Credit Card _____

Your co-payment is required at the time you check-in for your appointment. If you fail to bring your co-payment and we must bill you for it, an administrative charge of $15 will be added to your bill.

All patient balances that are past due (greater than 30 days) will accrue an interest charge of $15 for each month of your outstanding patient-due balance.

I understand and agree that I (or the person named below who is financially responsible for me) am financially liable for all services rendered and will pay my outstanding balance within 10 days of receipt of my monthly statements. I also understand that if my insurance plan does not pay Kathy Karamlou, M.D., Inc. within 60 days of services billed, the balance will be transferred to my responsibility and payment will be due at that time.

Patient Printed Name	Responsible Party's Printed Name
Patient's Signature	Responsible Party's Signature
Date	Date

Revised 120107

Name:

Ethnicity: Non-Hispanic, Hispanic, *or* Not Specified
(circle one)

Preferred Language:

Race: *(Check all that apply)*

- ☐ African or African American
- ☐ Asian or Asian American
- ☐ Caucasian or European American
- ☐ Native American or Native Alaskan
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race