Sandhills Rheumatology

Suneetha Morthala, M.D., F.A.C.R.

Patient Information

Full Name: _____ Date of Birth: _____
Address: _____
City/State: _____ Zip Code: _____ Sex: Male Female
Phone # (Home): _____ (Cell): _____ (Other): _____
Social Security Number: _____-_____-_____
Employer/Occupation: _____ City/State: _____
Marital Status: _____ Email Address: _____
Is the patient currently a nursing home resident? YES/NO
Does the patient have a caregiver we should use as a primary contact? YES/NO
If yes:
Caregiver Name: _____ Relationship: _____
Phone #: _____ Power of Attorney? YES/NO

**If Responsible Party is not the patient (or insurance is in another person's name), please complete the following with Responsible Party's information:
Full Name: _____ Date of Birth: _____
Address: _____
City/State: _____ Zip Code: _____ Sex: Male Female
Phone # (Home): _____ (Cell): _____ (Other): _____
Social Security Number: _____-_____-_____
Employer/Occupation: _____ City/State: _____
Marital Status: _____ Email Address: _____

EMERGENCY CONTACT Information:
Name: _____ Relationship: _____
Phone: 1._____ 2._____

Referring Provider Information (if this is not your first visit with Dr. Morthala, please list Primary Care Provider's information):
Doctor/Office Name: _____
Phone Number: _____ Fax: _____

I authorize release of any medical information necessary to process this claim and authorize payment of these services or benefits to Physician or supplier for services rendered.
Patient or Authorized Person's Signature: _____

It is the policy of our office that all fees are due at the time services are rendered, unless prior arrangements have been made. We welcome any calls requesting information for services and fees prior to treatment in order to prevent misunderstandings. We will be pleased to provide you with complete standard claim form which you can submit to your insurance company for reimbursement. Regardless of insurance coverage, you are responsible for payment of your account within the credit policy of this office. **Patient or Authorized Person's Signature:** _____

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Patient Name: _____ DOB: _____

Reason for Today's Visit: _____

Please describe the problem that troubles you the most _____

_____

Past Medical History Have you had any of the following? Please provide details if applicable.				
Diagnosis	YES	NO	Approx. Date of Onset	Additional Information
Cancer				
Cholesterol				
Diabetes Mellitus				
Heart Problems				
Lung Problems				
Kidney Problems				
Hepatitis				
Hypertension				
Peptic Ulcers				
Thyroid				
Tuberculosis				

Please List any Surgical Procedures, Hospitalizations or Broken Bones and Fractures

Drug Allergies	
Name of Drug	Describe Reaction (itching, rash, wheezing etc...)

Medications

Name of Medication	Dosage	Frequency

Past Medications		
Name of Medication	Dosage	Frequency

Medical History For Women Only		
Number of Pregnancies		Date of Most recent Pap Smear and Breast Exam:
Number of Miscarriages/Abortions		
Number of Live Births		Date of Last Bone Density Scan:
Age of Onset of Menstrual Periods		

Family History				Social History
Diagnosis	Mother	Father	Siblings	Do you smoke? YES NO If so # of Packs per day?
Lupus				
Rheumatoid Arthritis				Do you drink alcohol? YES NO If so how often?
Polymyositis				
Scleroderma				Marital Status:
Sjogrens Syndrome				Do you Exercise?
Gout				Current Occupation: Past Occupations:
Osteoarthritis				

Please Check all that Apply

- ☐ History of Rheumatic fever, Scarlet fever or heart murmur
- ☐ Frequent or Severe headaches, blurred vision, blind spots
- ☐ Awakening at night to urinate (# of times____)
- ☐ Pain in the Achilles Tendon
- ☐ Sleeping on more than one pillow
- ☐ Changes in color of fingers or toes on cold exposure
- ☐ Diarrhea lasting longer than 2 weeks
- ☐ Fatigue of jaw muscles while chewing
- ☐ Frequent mouth ulcers or sore mouth
- ☐ Pleurisy
- ☐ Vomiting of material resembling coffee grounds
- ☐ Pain in soles of feet
- ☐ Swelling around ankles
- ☐ Pericarditis
- ☐ Stiffness in joints after getting up in the mornings
- ☐ History of frequent abdominal pain
- ☐ Change in sense of smell or taste
- ☐ Change in fingernails or toenails
- ☐ Pain or Burning on urination
- ☐ Thinning of Scalp hair
- ☐ Skin rash on sun exposure
- ☐ Swollen lymph nodes or glands
- ☐ Bright Red blood in stools
- ☐ Pink Eye
- ☐ History of kidney stones
- ☐ Skin thickening or tightness
- ☐ Frequent mucus in stools
- ☐ Rash underneath eyes
- ☐ History of asthma
- ☐ History of hiatal hernia
- ☐ Prolonged Cough
- ☐ Shortness of breath
- ☐ Black/ Tarry Stools
- ☐ Emphysema
- ☐ Painful intercourse
- ☐ Muscle Weakness
- ☐ Ringing in ears
- ☐ Frequent heartburn
- ☐ Difficulty swallowing
- ☐ Swelling around eyes
- ☐ Frequent bronchitis
- ☐ Severe dry mouth
- ☐ Palpitations
- ☐ Severe Dry Eyes
- ☐ Chest Pain
- ☐ Tender Scalp
- ☐ Skin Nodules
- ☐ Blood in Urine

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Consent For Treatment

I, _____, hereby authorize Dr. Suneetha Morthala to perform medical examinations, procedures and tests she may deem necessary in my treatment. This may include (but is not limited to) referrals, insurance authorizations, labs, ultrasound, injections, etc.

_____
(Signature)

If you consent to someone other than yourself or your power of attorney having access to your protected medical information, please list them below. Persons not listed below will NOT be given information about your care under any circumstances.

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____
3. Name: _____ Relationship: _____

Signature: _____ Date: _____

Phone Message Consent

Do you consent to Sandhills Rheumatology leaving detailed messages on your voicemail/answering machine regarding your medical care? This may include (but is not limited to) appointment details, prescription information, labs, billing, and nurse calls.

YES_____ NO_____

*YES, but only on the following phone number: _____
(please list telephone number here)

Signature: _____ Date: _____

***You may revoke any part of this form at any time. By revoking the top consent portion, you forego any further medical treatment by Sandhills Rheumatology or Dr. Morthala. Revoking consent does NOT relieve you from any financial obligations which occurred while it was effective.

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Notice of Privacy Practices Acknowledgement and Patient Consent

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, Plan, and direct my treatment and follow up among the multiple healthcare providers who may handle my information directly or indirectly.
- Obtain payment from respected payers.
- Conduct all healthcare operations such as quality assessments and physician certifications.

I have received and read the Notice of Privacy Practices containing a more detailed description of how my health information may be disclosed. I understand that I may request a current copy of the Notice of Privacy Practices at any time from this facility. It can also be viewed by visiting our website www.sandhillsrheumatology.com.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand this practice is not required to agree to my requested restrictions, but if agreed upon by the practice, we are then bound to abide by such restrictions.

Date: _____

Patient Name: _____

Signature: _____

Relationship to Patient (if under 18 years of age): _____

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