Name: _____ Sex:M/F Date of Birth: _____

Address: _____ City:_____ Zip:_____

Home Phone:_____ Email Address:_____

Social Security #:_____ Employer:_____

Cell phone #:_____

Marital Status:_____ Spouse Name:_____

Nearest Relative:_____ Phone:_____

Emergency Contact Person:_____ Phone:_____

A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by the insurance company. I also authorize the release of my medical records to any physician or any appropriate insurance carrier.

Signature of patient/legal guardian_____Date_____

MEDICATION LIST

Patient Name:_____DATE:_____

Pharmacy Name:_____ Pharmacy Phone #:_____

Pharmacy Address:_____

Please list **ALL MEDICATIONS** that you are currently taking. Also list the **Strength** and **how often** you take each medication.
Medication:

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

9)_____

10)_____

Please list **ALL** medication **Allergies**:

_____

NAME: _____DOB:_____ETHNICITY: _____

WHAT IS YOUR REASON FOR VISIT TODAY? _____

_____

_____

_____

PAST/CURRENT MEDICAL ISSUES (circle all that apply):

High blood pressure	Diabetes	Hepatitis/Liver Disease
High cholesterol	Thyroid disease	Stroke
Arthritis	GERD/gastritis	Heart attack/heart disease
Lupus	Urinary tract infections	Seasonal allergies
Gout	Kidney Disease	

OTHER: _____
(PLEASE USE BACK OF PAPER IF YOU NEED MORE ROOM)

PAST SURGERIES:

_____

_____

MEDICATIONS/ALLERGIES: SEE OTHER FORM

FAMILY HISTORY: (age, living/deceased, medical problems)

Mother: _____

Father: _____

Siblings: _____

Children: _____

Other history of: Arthritis Lupus Cancer Diabetes Gout Thyroid

SOCIAL HISTORY: (Circle one)

TOBACCO: *Never Past Present* (if currently how many cigarettes/day): _____
ALCOHOL: *Never Past Occasionally Regularly* (amount/day or week): _____
DRUGS: Never Past Occasionally Regularly (amount/day or week): _____
OCCUPATION: _____
MARITAL STATUS: _____ # OF PEOPLE LIVING WITH YOU:_____
DATE & RESULTS OF YOUR LAST HIV TEST:_____
DATE & RESULTS OF YOUR LAST TB SKIN TEST:_____
HISTORY OF BLOOD TRANSFUSIONS: Yes/No
HISTORY OF TATTOOS: YES/NO

Name:_____ DOB:_____

REVIEW OF SYSTEMS:

ARE YOU **CURRENTLY** EXPERIENCING (and not listed above):

General:
Fever
Chills
Weight gain/loss
Fatigue
Malaise
Dizziness

GI:
Stomach ache
Reflux
Nausea/Vomiting
Diarrhea
Constipation
Hemorrhoids
Black/Tarry stools

Skin:
rash
Sunburn
Rash in the sun
Psoriasis
Hair loss
Nail changes

Hem/Onc:
Easy Bruising
Bleeding(nose or other)
Cancer type:_____

HEENT:
Vision changes
Dry eyes
Double vision
Sores in nose

ENDOCRINE:
Diabetes
Thyroid disease
Hot/cold intolerance

CARDIAC:
Chest pain
Palpitations
Irregular heartbeat
Congestive Heart Failure

MSK:
Joint swelling
Muscle Pain
Joint redness
Joint pain

GU:
Pain with urination
Difficulty starting/stopping urine
Incontinence
Discharge
Painful intercourse

PULMONARY:
Shortness of breath
Wheezing
Cough
Tuberculosis
Bloody sputum
Snoring
Sleep apnea

NEURO/PSYCH:
Anxiety
Depression
Mood swings
Tingling/numbness
Seizures
Headache

THIS PATIENT CONSENT FORM IS FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION, FOR TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS.

I, _____, understand that as part of my health care, Dr.Chandrakant Mehta, Dr.Amal Mehta, Dr.Dharmarajan Ramaswamy, Dr. Janki Trivedi, Lisa Garcia NP-C, Angel Bustamante PA-C, Keith Colburn, M.D, Naila Ahmad M.D, Natalia Chavez-Chiang,MD. Southland Arthritis & Osteoporosis Medical Center, C.V.Mehta MD Medical Corporation and their affiliates originates and maintains paper and/or electronic medical records describing my health history, symptoms, examination, test results, diagnosis, treatment, and any plans for the future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that the services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a notice of information practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent,
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care options.

I understand that Dr.Chandrakant Mehta, Dr.Amal Mehta, Dr.Dharmarajan Ramaswamy, Dr. Trivedi, Lisa Garcia NP, Angel Bustamante PA, Naila Ahmad M.D., Natalia Chavez-Chiang, MD, Southland Arthritis & Osteoporosis Medical Center, C.V.Mehta MD Medical Corporation and their affiliates are not required to agree to the restrictions requested. I understand that they may revoke this consent in writing. I also understand that by refusing to sign this consent, this organization may refuse to treat me as permitted by section 164:506 of the code of Federal Regulations. I understand that Dr.Chandrakant Mehta, Dr.Amal Mehta, Dr.Dharmarajan Ramaswamy, Dr.Janki Trivedi, Lisa Garcia NP, Angel Bustamante PA, Keith Colburn M.D., Naila Ahmad M.D., Natalia Chavez-Chiang MD, Southland Arthritis & Osteoporosis Medical Center, C.V.Mehta MD Medical Corporation and their affiliates reserves the right to change this notice and practices in accordance with section 164:520 of the code of Federal Regulations. Should this organization change the notice, they will send me a copy of any revised notice to the address I've provided (whether by U.S. mail or by Email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care options, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax, answering machine, or a family member. I fully understand and accept the terms of this consent.

_____ _____

Patient's Signature Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize:_____

To furnish all medical records concerning patient:

Name:_____

DOB:_____

Disclose Medical Records To: **Southland Arthritis**

☐ Hemet Office: 949 Calhoun Pl, Suite F, Hemet, CA 92543
Phone (951)652-5000; Fax (855) 306-0135

☐ Menifee Office: 29798 Haun Rd, Suite 301, Menifee, CA 92586
Phone (951) 672-1866; Fax (855) 306-0135

☐ Temecula Office: 31515 Rancho Pueblo Rd, Suite 203, Temecula, CA 92592
Phone (951) 303-1500; Fax (855) 306-0135

☐ Riverside Office: 21832 Cactus Ave, Riverside, CA 92518
Phone (951)924-6500; Fax (855) 306-0135

☐ Corona Office: 770 Magnolia, Suite 1C, Corona, CA 92879
Phone (951)256-1779; Fax (855) 306-0135

This authorization shall become effective immediately and shall remain in effect for thirty six (36) months from the date of the signature. This authorization is also subject to written revocation by the undersigned at any time between now and the disclosures of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the Requester or others have acted in reliance upon this authorization. I understand and agree that there are some circumstances where information relating to my claim may be disclosed to other parties, including, but not limited to, Hospitals, Physicians, Clinics, Medical Providers, or other Social Service Agencies which may have previously rendered services to me and/or have consulted with me in regards to my claim for benefits.
Specify records to be disclosed: **Complete Medical Records, including but not limited to: psychiatric/mental health records (protected by the Lanterman-Petris-Short act), Drug and/or alcohol abuse records, records concerning infectious disease, sexually transmitted disease (including HIV)**
If any except specifically provided:_____
I understand that I have the right to receive a copy of this authorization

Signature:_____

Date:_____

SOUTHLAND ARTHRITIS AND OSTEOPOROSIS CENTER

PATIENT CODE OF CONDUCT

Welcome to Southland Arthritis and Osteoporosis Center. The providers and staff strive to make your healthcare experience the best it can be while under care of the practice. We understand that there may be times you may be frustrated due to your current health concerns or other personal reasons. The staff and physicians at Southland Arthritis and Osteoporosis center will make every attempt to accommodate your needs and concerns.
However, the staff nor the physicians will tolerate any of the following:

- Verbal abuse for any reason
- Physical abuse
- Repeated missed appointments (3 or more No Show/ Canceled appointments)
- Refusal to go to the emergency room as directed by the physician or staff on behalf of the physician
- Failure to follow medical advisement such as recommended testing, medication instructions, laboratory testing or procedures

Not following physician recommendations may compromise the quality of your care and certain behaviors as listed above will not be tolerated by the practice. Southland Arthritis and Osteoporosis Center is providing this Code of Conduct so that there is a clear understanding as to why the practice may elect to discharge a patient from the practice for any of the above breach in the Patient Code of Conduct policies.

Thank you for your understanding.
Southland Arthritis and Osteoporosis Center
C.V. MEHTA, M.D., F.A.C.R
D. RAMASWAMY, M.D.
J. TRIVEDI, M.D.
A. MEHTA, M.D., M.B.A.
L. GARCIA, NP-C
A. BUSTAMANTE, PA-C
K. COLBURN, M.D
N. AHMAD M.D.
N.CHAVEZ CHIANG, M.D

Print Patient Name_____ Date_____

Patient Signature _____ Date of birth_____

Southland Arthritis & Osteoporosis Medical Center

New Patients/Follow up Patients

Missed appointments Fees and Rescheduling
Our physicians want to be available for your needs. Unfortunately, when a patient does not show for their scheduled appointment, another patient loses an opportunity to be seen. So if you are not able to make your appointment, **please call us 48 hours before your scheduled appointment, otherwise a fee of $50 will be billed**. Schedules fill up quickly, if you miss an appointment without calling, we may not be able to reschedule as soon as you would like. This policy enables us to better utilize available appointment for our patients in need of medical care.

- If you are 15 minutes late to your scheduled appointment, **YOU WILL NOT BE SEEN**.
- If you are a follow up patient, and you do not give us a 24 hour cancellation notice, or you do not show up for your appointment, **you will be charged a $25 fee**.

Copays and other charges due at time of visit
Copayment is expected at the time of service. Services provided which are not a covered benefit of your health plan will be **YOUR financial responsibility**.

How to refill a prescription
If you need a prescription refilled, **PLEASE PLAN AHEAD**. Many Rheumatology medication should not be discontinued or stopped unexpectedly, **Call your pharmacy to request a refill 5 working days in advance. DO NOT CALL OUR OFFICE.** Requests must go through the pharmacy. If you already have refills authorized, the pharmacist will notify our office. It will take 3-5 working days to complete authorization for your prescription and inform the pharmacy. Mail order prescriptions will also need 5 working days to complete.

Forms/Records Request
There is a charge for most forms, such as Jury Duty excuse, DMV placard, Disability, FMLA, etc.
If you are coming from another medical group or doctor's office, you can request your records be sent here. A signed medical release by you will initiate that a copy of your records be sent. The form will need your signature and it can be faxed or mailed to your previous physician's office, If you are already an existing SOuthland Arthritis patient and an outside physician is requesting your records, a signed release is also needed. It will take 15 working days and have your records sent.

Print Name_____ Date_____

Signature_____

Medical Information Release Form (HIPAA)

Name: _____ Date of Birth: _____

Release of Information

I authorize the release of information including the diagnosis, records, examination results, medication dose changes, appointments, and claims information.
This information may be released to:

☐ Spouse_____

☐ Child(ren)_____

☐ Other_____

Correspondence

Please call
☐ my home #_____ ☐my cell #_____
If unable to reach me:
☐ you may leave a detailed message
☐ please leave a message asking me to return your call
The best time to reach me is (day of week)_____ between (time)_____

☐ E-mail me a detailed message at:_____

☐ Mail correspondence to my home address:_____

Appointment Reminders

☐ may call or text the numbers above ☐ may e-mail me at the address above

This Release of Information will remain in effect until terminated by me in writing. This release specifically excludes any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Patient Signature _____ Date_____

SOUTHLAND ARTHRITIS AND OSTEOPOROSIS CENTER
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I am acknowledging that: I am either the patient or the patient's personal representative; I have received a copy of the " Notice of Privacy Practices: for Southland Arthritis and Osteoporosis center; and I understand that I may contact the company named in the Notice if I have questions about the content of the Notice.

_____ _____
Name of Patient Date of birth

_____ _____
Signature of Patient/legal representative Date

_____
Description of relation to patient

TO BE COMPLETED BY STAFF

Part 1: Complete if signature requested but not obtained: Staff member sought but was unable to obtain an acknowledgement from the patient or the patient's personal representative for the following reason:

- ❑ Patient/personal representative refused to sign
- ❑ other: _____

Part 2. Complete if patient/personal representative unavailable to sign form on the first date of service:

- ❑ Form mailed/sent to patient/personal representative on:_____

Part 3. Complete if either Part 1 or Part 2 completed:

_____ _____
Signature of staff member Date