PENNSYLVANIA
RHEUMATOLOGY
ASSOCIATES, PC

520 Maple Ave
Suite 4
West Chester, PA 19380
T: 215-829-5358 F: 215-923-6442
parheumatologyassociates.com

Scheduled Date:

Scheduled Time:

Welcome to PA Rheumatology Associates, P.C. in West Chester. Dr. David Chen, MD is looking forward to meeting with you and participating in your care. We have set aside an hour for your appointment, and because of this require 24 hours notice for all cancellations in order to avoid a fee ($75 for new patients and $35 for follow-ups).

**** Bring the following to your visit:**

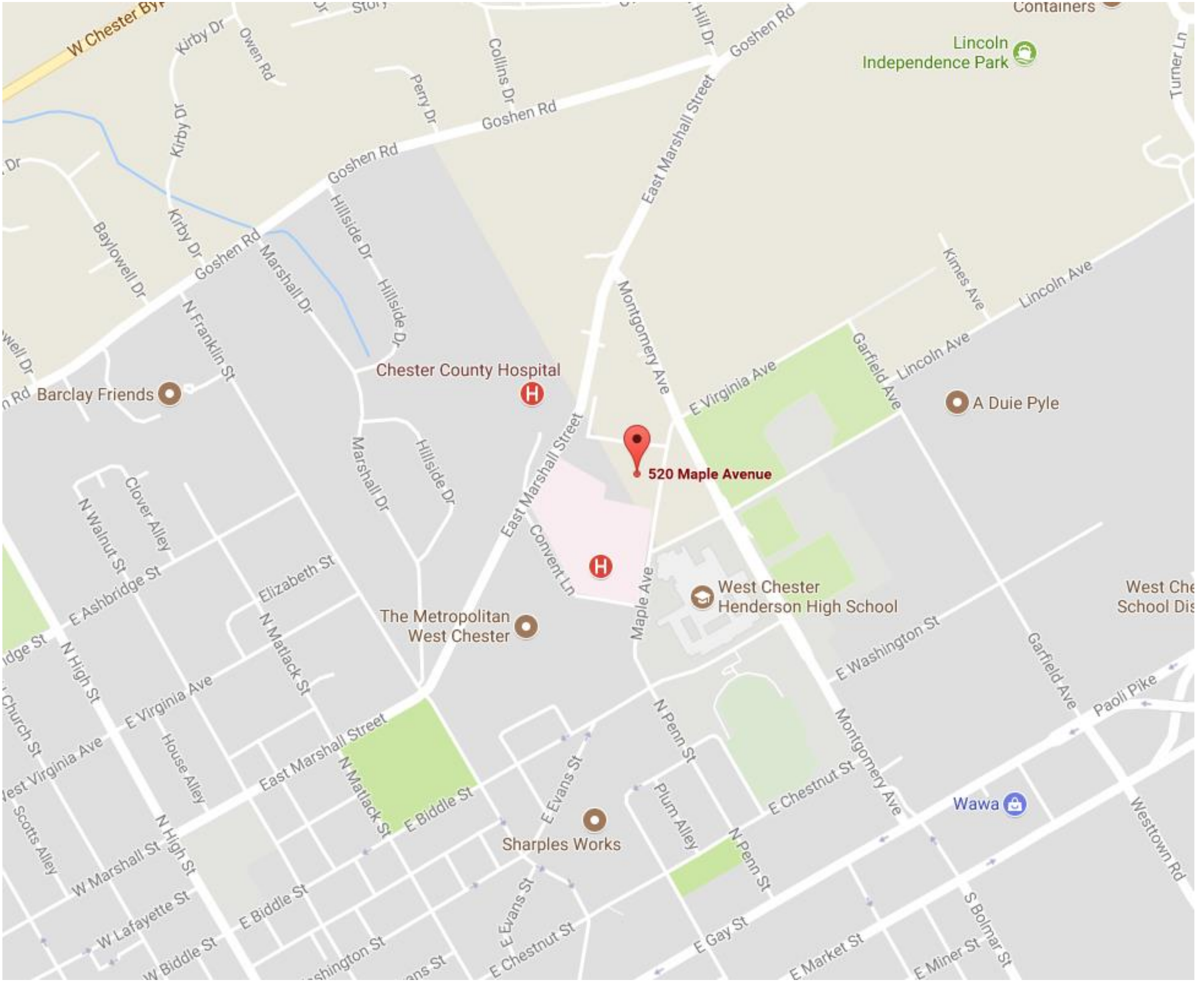
1. Insurance Card
2. Prescription Card
3. Completed Forms (enclosed)
4. Medical Records

It is important for you to bring any medical reports, laboratory test results and/or x-ray reports with you to your appointment. Please do not mail or fax any records prior to your visit.

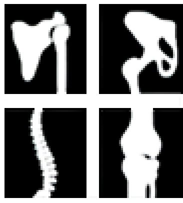
If your insurance plan requires a referral, please request it from your Primary Doctor's office at least 1 week prior to your visit with us. Our provider number for referrals is 1801841739.

Any applicable co-pays will be billed to you from our main office in Philadelphia. If you have Healthspring, we do not accept Access. This means that you will have a copay in our office.

*****If your Plan requires a referral, you must have it at least 48 hours prior to your visit*****



W Chester Byp
Containers
Lincoln Independence Park
Turner Ln
Kirby Dr
Owen Rd
Collins Dr
Hill Dr
Goshen Rd
Perry Dr
East Marshall Street
Baylowell Dr
Hillside Dr
Marshall Dr
N Franklin St
Kimes Ave
Lincoln Ave
Montgomery Ave
Chester County Hospital
Barclay Friends
E Virginia Ave
Garfield Ave
A Duie Pyle
520 Maple Avenue
Clover Alley
N Walnut St
Convent Ln
E Ashbridge St
Elizabeth St
West Chester Henderson High School
Maple Ave
The Metropolitan West Chester
N Matlack St
N High St
E Washington St
Church St
House Alley
West Virginia Ave
N Penn St
Paoli Pike
E Evans St
Scotts Alley
E Biddle St
Plum Alley
E Chestnut St
Wawa
Sharples Works
W Marshall St
W Lafayette St
Westtown Rd
W Biddle St
E Gay St
E Market St
E Miner St
S Bolmar St



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Personal information *(please print)*

Name____Gender____________

Social Security Number________________________ Date of Birth____________________

Address____

City______________________________ State__________ Zip Code______________

Primary Phone Number_______________________ Alternate phone____________________

Email ____

Language *(if other than English)* _______________________________________

Emergency Contact

Name____

Phone #_________________________ Relationship to patient______________________

Primary Care Doctor

Name ___________________________

Address _________________________

Phone #__________________________

Fax#____________________________

Referring Doctor

Specialty ________________________

Name ___________________________

Address _________________________

Phone #__________________________

Fax#____________________________

Local Pharmacy

Name ___________________________

Address _________________________

Phone #__________________________

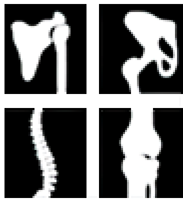
Fax#____________________________

Mail Order Pharmacy

Name ___________________________

Phone #__________________________

Fax#____________________________



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Insurance information

Plan Name ____

ID# ______________________ Group/Account# ______________________

Relationship to insured (self, spouse, other) ______________________

Employer ____

Primary Insurance Holder

Name ______________________ Date of Birth ______________________

Secondary Insurance

Plan Name ____

ID# ____

Relationship to insured______________________

Prescription Plan

Plan Name ____

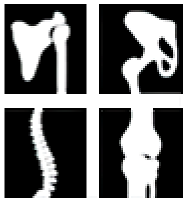
ID#______________________ Pre-auth phone #______________________

For legal purposes, we require your signature at the bottom of the following statement:

"I request that payments by authorized insurances be made on my behalf to PA Rheumatology Associates, PC, for services furnished by their physicians. I understand that payment is due at the time of my visit if I do not have insurance. I understand that my co-pay (if applicable) is due at the time of my office visit and if it is not paid at that time, there will be an additional $30 fee. I understand that any deductibles are my responsibility. I also agree to give ***at least 24 hours*** *notice of all cancellations or else I will be charged an appropriate fee."*

Print Name: ____

Signature: ______________________________ Date______________________



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Name ____ DOB ________________________

Personal Health History

Height:	**Weight:**

Medications including strength/ frequency *(example: Aspirin 81mg once a day, Calcium 500mg twice a day)*

1) ____ 6) ____

2) ____ 7) ____

3) ____ 8) ____

4) ____ 9) ____

5) ____ 10) ____

Past or current medical conditions *(Please circle all that apply)*

Diabetes	High blood pressure	Cholesterol	Heart Attack	Stroke	Acid reflux
Kidney disease	Liver disease	Hepatitis	HIV/AIDS	Hypothyroid (low thyroid)	Asthma
Emphysema/COPD	Anemia	Anxiety	Depression	Fibromyalgia	Osteoporosis/ Osteopenia
Rheumatoid Arthritis	Osteoarthritis	Lupus	Psoriasis	Psoriatic arthritis	Gout

Other Medical Problems Not Listed Above

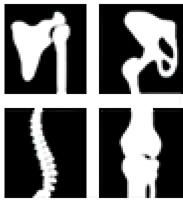
1) ____ 6) ____

2) ____ 7) ____

3) ____ 8) ____

4) ____ 9) ____

5) ____ 10) ____



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Name ____ DOB _______________________

Personal Health History (Continued)

Allergies to Medications and/or Foods and Type of Reaction *(example: penicillin – hives)*

1) ____ 6) ____

2) ____ 7) ____

3) ____ 8) ____

4) ____ 9) ____

5) ____ 10) ____

Previous Surgeries and Dates *(example: Gall bladder removal April 2010)*

1) ____ 6) ____

2) ____ 7) ____

3) ____ 8) ____

4) ____ 9) ____

5) ____ 10) ____

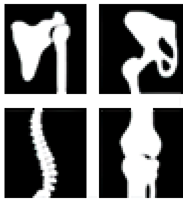
Family Health History

Mother: ____ DOB _______________ Current Age ___________

Father: ____ DOB _______________ Current Age ___________

Siblings: ____

Children: ____



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Name ____ DOB ____________________

Review of systems

Do you or have you had any of the following in the past six months *(Please circle all that apply)*

General	HEENT	Skin	Cardio/Pulmonary	Gastrointestinal
Fevers Weight loss Night sweats	Dry eyes Dry mouth Oral ulcers Vision problems Hearing loss Nasal congestion Nosebleeds	Rash Psoriasis Hair loss Nail changes	Chest Pain Palpitations Shortness of breath Cough Leg swelling	Heartburn Ulcers Abdominal pain Nausea Vomiting Diarrhea Constipation Blood in the stool
Genitourinary	**Neurological**	**Musculoskeletal**	**Psychiatric**	**Hematological**
Pain with urination Incontinence Blood in urine STDs Miscarriages	Numbness Tingling Weakness Headache Migraines Seizures	Joint pain Joint swelling Muscle pain Back pain Neck pain	Anxiety Depression Difficulty sleeping	Bleeding disorder Easy bruising Anemia Blood clots

Other

Occupation (*if retired, what did you previously do?*): ______________________________________

Marital status: ___________________________ Children? ________________________

Do you drink alcohol? *(yes or no)* ________ If Yes, how many? _______ drinks per *(day, week, month, year)*

Do you smoke? *(yes/no/former)*______________ How many?____________ Date Stopped _______________

Do you consume caffine? (yes/no) ____________________ How many cups per day? ___________________

Do you do any drugs? (*marijuana, cocaine, etc*)?____

Any Additional Information

____
____
____

Date: ___________________

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notices of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

____ ____
Please PRINT your name Please SIGN your name

____ ____
Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: ____
____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA
_____ First Name Only _____ Proper Sur Name _____Other ___________________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION
This includes step parents, grandparent, and any care takers who can have access to this patient's records

Name ____ Relationship ___________________________________

Name ____ Relationship ___________________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT, & BILLING INFORMATION VIA:
_____ Cell Phone _____ Text Message _____ Home Phone _____ Work Phone _____ Email
_____ Any of the above

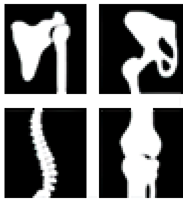
I AUTHORIZE INFORMATION ABOUT MY HEALTH TO BE CONVEYED VIA:
_____ Cell Phone _____ Text Message _____ Home Phone _____ Work Phone _____ Email
_____ Any of the above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING ERROFTS, OR NEW HEALTH INFO ON BEHALF OF THIS HEALTHCARE FACILITY VIA:
_____ Phone Message _____ Text Message _____ Email
_____ Any of the above _____ None of the above (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only: As Privacy Office, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:
___ It was emergency treatment ___ I could not communicate with the patient ___ The patient refused to sign ___ Other __________________

____
Signature of Privacy Officer



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Date: ____

To: ____

Address: ____

____

Fax: ____

Patient Name: ____

Patient DOB: ____

Please forward a copy of my complete records, including all doctors' reports, labs, and imaging to:

Pennsylvania Rheumatology Associates, P.C.
822 Pine Street Suite 3A
Philadelphia, PA 19107
Fax: 215-923-6442

Signature: ____

Date: ____