RHEUMATOLOGY CONSULTANTS, L.L.P.

Patient's Name ______________________________ Date ____________

Address ____

City ________________ State ______________ Zip Code __________

Age ______ Date of Birth __________ Social Security # ____________ Marital Status ______

Race __________ Ethnicity ________ Preferred Language ____________________

Home Phone # ____________ Work Phone # ____________ Cell Phone # ____________

E-mail address: ____

Referring Physician/Internist ______________________________________

Physician's address ____________________________ Phone number ____________

Pharmacy Name & Phone ______________________________________

Patient's Occupation ______________________ Employer ____________________

Employer's Address & Phone ______________________________________

Name of Spouse ______________________ Spouse's Date of Birth ____________

Spouse's Employer ______________________ Spouse's Social Security # ____________

Employer's Address & Phone ______________________________________

Emergency Contact __________________ Relationship __________ Phone # __________

Primary Insurance Information

Company Name ____________________ Address ______________________

Contract Holder ____________________ I.D. # ______________________

Secondary Insurance Information

Company Name ____________________ Address ______________________

Contract Holder ____________________ I.D. # ______________________

*****NOTICE TO PATIENTS*****

Dr's Cohen, Kaplan, Levine, Brodsky & Klein practice strictly Rheumatology, and do not perform cardiac, breast or rectal exams.

Patient Name: ______________________ Date: __________ MR# ______________

<u>Medications</u>

____

____

____

____

<u>Past Medical History</u>

Hypertension	Y or N	Colitis	Y or N
Diabetes	Y or N	Rashes	Y or N
Cancer	Y or N	Tick Bites	Y or N
Psoriasis	Y or N	Ulcers	Y or N
Kidney stones	Y or N		

<u>Previous Hospitalizations/Reason/dates</u>

____

____

<u>Other major illnesses</u>

____

____

<u>Date of last Chest X-ray</u> _______

<u>Any active dental problems</u> ? ___________

<u>Date of last Bone Density Scan (DEXA):</u>

____

Allergies to medications & reaction

____

____

Date of last influenza vaccine: ______

Date of last pneumonia vaccine: _____

<u>FAMILY HISTORY OF ARTHRITIS/GOUT/LUPUS</u>

____

Alcohol Y or N Amount: __________________

Cigarettes Y or N Amount: __________________

Lives with: Spouse/children/parent/other/alone Steps at home: Y or N

I have reviewed the above Review of Symptoms/Medical history with patient.

____
(physicians signature)

____
Date

RHEUMATOLOGY CONSULTANTS, LLP

DANIEL H. COHEN, M.D.
STUART D. KAPLAN, M.D.
BENJAMIN E. LEVINE, M.D.
JORDAN E. BRODSKY, M.D.

RHEUMATOLOGY
OSTEOPOROSIS
FELLOWS, AMERICAN COLLEGE OF RHEUMATOLOGY

SIGNATURE ON FILE FORM

I request that payment of authorized ______________________________
benefits be paid on my behalf to Dr's Cohen, Kaplan, Levine, Brodsky & Klein (RHEUMATOLOGY CONSULTANTS, LLP) for any services furnished to me by these physicians. I authorize any holder of medical information about me to release to ______________________________ and its agents any information needed to determine these benefits payable for related services.

______________________	______________________
Patient's Name	Health Insurance Number
______________________	______________________
Patient's Signature	Date

1157 BROADWAY • HEWLETT, NY 11557 • TEL: (516) 295-4481 • FAX: (516) 295-4809

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SIGNATURE ON FILE (MEDICARE)

I request that payment of authorized Medicare benefits be made on my behalf to Dr's Cohen, Kaplan, Levine, Brodsky & Klein (RHEUMATOLOGY CONSULTANTS, LLP) for services furnished to me by Dr's Cohen, Kaplan, Levine, Brodsky & Klein (RHEUMATOLOGY CONSULTANTS, LLP). I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorization release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

Dr's Cohen, Kaplan, Levine, Brodsky & Klein (RHEUMATOLOGY CONSULTANTS, LLP) accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

______________________________ ______________________________
Patient's Name Medicare Number

______________________________ ______________________________
Patient's Signature Date

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I, ______________________________________, acknowledge that I have been provided with a copy of **Rheumatology Consultants, L.L.P.**'s privacy notice.

____
Signature

____
Print Name

____
Date

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AUTHORIZATION FORM FOR PATIENT RECORDS RELEASE

Section A: Must be completed for all authorizations:

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. Any health information disclosed pursuant to the authorization subject to redisclosure by the recipients and may no longer be protected by the Federal privacy regulations.

Patient Name: ______________________ ID# ______________________

Persons/organizations authorized to use or disclose my information:

____

Persons/organizations who may receive my information:

____

Specific description of the information to be used or disclosed (including date(s)):

____

Description of each purpose of the use or disclosure of my health information: (Note: if the release of information is requested by the patient, please insert "at the request of the patient" here if the patient does not provide a statement of purpose.)

____

Section B: the patient of the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ______________(date) Initials__________

2. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. Initials__________

3. I understand that I will get a copy of this form after I sign it. Initials__________

4. I understand that I may revoke the authorization at any time by notifying the Practice in writing, but if I do, the revocation will not have any effect on actions the Practice has already taken in reliance on this authorization. Initials__________

______________________ ______________________

Signature of patient or patient's representative Date

If this authorization is signed by a patient's representative, please complete the following:

______________________ ______________________

Printed name of patient's representative Relationship to patient

Describe the representative's authority to act for the patient:

____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION