West Michigan Rheumatology, PLLC

Richard W. Martin, M.D., M.A
Andrew J. Head, M.D.
Aaron T. Eggebeen, M.D.
Eric T. Slavin, M.D.

"Research Inspiring Care"
www.mi-arthritis.com

1155 East Paris Ave SE, Ste 100
Grand Rapids, MI 49546
Phone: 616.459.8088
Fax: 616.459.8312

Dear _____,

Enclosed, you will find a Patient Registration Form and two questionnaires. Please complete these forms prior to your first visit and bring them along with you to your first visit with:

Richard W. Martin, M.D., M.A. **Aaron T. Eggebeen, M.D.**

Andrew J. Head, M.D. **Eric T. Slavin, M.D.**

You must be at the office for Pre-Registration/Check-In at: _____AM/PM

The appointment is scheduled for: _____, at _____AM/PM

****Please keep in mind the appointment is 1-hour long. If you cannot make the appointment, please give us as much notice as possible.**

Please bring the following to your first visit:

1. The **COMPLETED** Patient Registration Forms, Notice of Privacy Practices, & Medical Questionnaires.
2. A valid driver's license or State Identification card with a photo is required at the first visit.
3. Proof of Insurance – Insurance cards need to be brought to every visit.
4. Insurance Copayments are due at the time of service for **EVERY** visit.
5. If you do not have insurance – payment **IN FULL** is due at the time of service.
6. Please bring your regular shoes, splints, canes, and other adaptive equipment.

General Office Policies:

1. **Office Hours:** Telephones are open Monday – Thursday from 8:15am-4:15pm. The office is closed for lunch from 12:15pm-1:15pm. On Fridays, the telephones are open from 8:15am-12:00pm. The office is closed on Friday afternoons.
2. **Telephone Calls: Our office phone number is 616.459.8088.**
   For calls after hours or during lunch:
   - If the office is closed and it is an emergency – please call 911.
   - For scheduling issues – a staff member can cancel/reschedule during regular office hours.
   - If you need to speak to the on-call physician after hours, you will be forwarded through the auto attendant and connected with one of the providers.
3. **The practice DOES NOT participate with Medicaid.** If the patient utilizes Medicaid as the Secondary Insurance Carrier – the practice will not accept it as payment. The patient and/or guardian will be responsible for any balance left after the payment from the Primary Insurance Carrier. The practice **WILL NOT** bill Medicaid.

West Michigan Rheumatology, PLLC

Richard W. Martin, M.D., M.A
Andrew J. Head, M.D.
Aaron T. Eggebeen, M.D.
Eric T. Slavin, M.D.

"Research Inspiring Care"
www.mi-arthritis.com

1155 East Paris Ave SE, Ste 100
Grand Rapids, MI 49546
Phone: 616.459.8088
Fax: 616.459.8312

Directions:

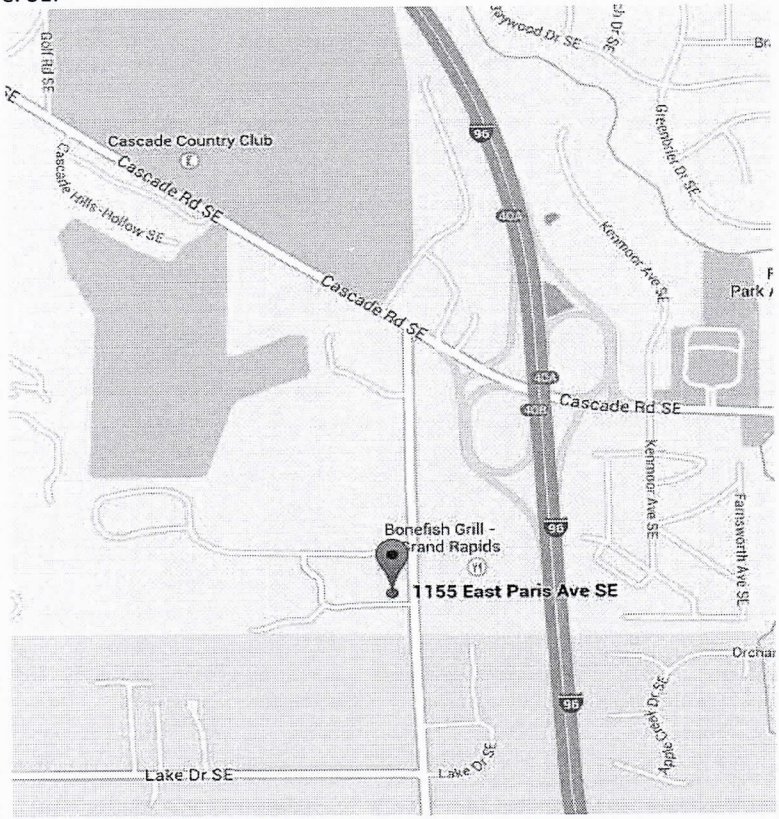
From North of Grand Rapids: Follow US-131 S to I-96 East. Take Exit 40 for Cascade Rd W. Stay in the 2nd lane to the right (labeled East Paris). Keep right on Cascade and turn left in 0.3 miles on East Paris Ave. Turn right in 0.4 miles into 1155 E. Paris Ave. SE.

From South of Grand Rapids (Kalamazoo): Take US-131 N toward Grand Rapids and merge onto M-6 E. Merge onto I-96 towards Muskegon. Take Exit 40 for Cascade Rd W. Stay in the 1st lane to the left (labeled East Paris). Keep left on Cascade and turn left in 0.3 miles on East Paris Ave. Turn right in 0.4 miles into 1155 E. Paris Ave. SE.

From East of Grand Rapids (Lansing): Take I-96 West toward Grand Rapids. Take Exit 40 for Cascade Rd W. Stay in the 2nd lane to the right (labeled East Paris). Keep left on Cascade and turn left in 0.3 miles on East Paris Ave. Turn right in 0.4 miles into 1155 E. Paris Ave. SE.

From West of Grand Rapids (Holland): Take I-96 E to M-6 East. Merge onto I-96 towards Muskegon. Take Exit 40 for Cascade Rd W. Stay in the 1st lane to the left (labeled East Paris). Keep left on Cascade and turn left in 0.3 miles on East Paris Ave. Turn right in 0.4 miles into 1155 E. Paris Ave. SE.

From West of Grand Rapids (Muskegon): Take I-96 E towards Grand Rapids. Take Exit 40 for Cascade Rd E. Stay in the 2nd lane to the right (labeled East Paris). Keep right on Cascade and turn left in 0.3 miles on East Paris Ave. Turn right in 0.4 miles into 1155 E. Paris Ave. SE.



West Michigan Rheumatology, PLLC

Richard W. Martin, M.D., M.A
Andrew J. Head, M.D.
Aaron T. Eggebeen, M.D.
Eric T. Slavin, M.D.

"Research Inspiring Care"
www.mi-arthritis.com

1155 East Paris Ave SE, Ste 100
Grand Rapids, MI 49546
Phone: 616.459.8088
Fax: 616.459.8312

Welcome to our practice!

Please read the following policies and procedures, then sign at the bottom of this page to indicate your understanding.

Appointments

- Please arrive on time for all scheduled appointments.
- If you cannot attend an appointment, please call and cancel your appointment at least 24 hours in advance.
- If you cancel an appointment less than 24 hours in advance, you will be charged a late-cancel fee of $30.
- If you do not cancel and do not attend an appointment, you will be charged a "no-show" fee. This fee will be $100 for New Patient appointments and $30 for follow-up appointments.

Insurance

- We expect you to pay your co-pay when you come into the office for your appointment.
- The patient and/or guardian are responsible for bringing his/her insurance card to **EVERY** visit.
- You are responsible for all fees if your insurance does not cover our services for any reason.
- We do not participate with Medicaid, as a primary or secondary insurance carrier, and cannot accept this insurance as a payment.
- If you do not pay an outstanding balance in a reasonable amount of time, you may be discharged from our practice.
- **If your insurance coverage changes/renews – it is your responsibility to alert the office staff of this change before the time of your appointment.**

Refill Requests

- All refill requests require at least 2 full business days to be processed. (Not including weekends or holidays)
- Sometimes you will need to attend an appointment before a medication can be refilled.
- If your medication is not covered by your insurance company or if you need a prior authorization/formulary exemption, please have your pharmacy fax us a request with your prescription plan information.

Office hours are Monday – Thursday 8am – 4:15pm and Friday 8am – 12:15pm by appointment only.
I acknowledge that I have read and understand the practice policies for West Michigan Rheumatology, PLLC.

_____

(Patient/Guardian Signature) (Printed Name)

(Date)_____

West Michigan Rheumatology, PLLC

Richard W. Martin, M.D., M.A
Andrew J. Head, M.D.
Aaron T. Eggebeen, M.D.
Eric T. Slavin, M.D.

"Research Inspiring Care"
www.mi-arthritis.com

1155 East Paris Ave SE, Ste 100
Grand Rapids, MI 49546
Phone: 616.459.8088
Fax: 616.459.8312

Patient Authorization of Personal Representative (HIPAA)

Form 7.30

Purpose of Request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information.

Please print all information, then sign and date form at the bottom.

Patient Name: _____

Social Security Number: _____ **Date of Birth:** _____

Individuals who I authorize to access my protected health information:

_____
Name Relation Date

_____
Name Relation Date

_____
Name Relation Date

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative(s).
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Officer. This can be done in-person or by mailing a request to:

  Contact: Privacy Officer
  Address: 1155 East Paris Avenue SE, Suite 100, Grand Rapids, MI 49546
  Phone: 616.459.8088
  Fax: 616.459.8312

Re-disclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under the authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

_____ _____
Patient Signature Date

Copies of signed authorizations are available upon request.

West Michigan Rheumatology, PLLC

Richard W. Martin, M.D., M.A
Andrew J. Head, M.D.
Aaron T. Eggebeen, M.D.
Eric T. Slavin, M.D.

"Research Inspiring Care"
www.mi-arthritis.com

1155 East Paris Ave SE, Ste 100
Grand Rapids, MI 49546
Phone: 616.459.8088
Fax: 616.459.8312

Patient Registration Form
(Please Print Clearly)

Referred By: Dr. _____
Address: _____
Phone: _____

Medical Allergies: _____

Do you have Health Insurance? _____ Yes _____ No

Primary Insurance Carrier: _____
Subscriber Name: _____
Birth Date: ___/___/___ Social Security Number: _____

Do you have a Secondary Insurance Carrier? _____ Yes _____ No

Secondary Insurance Carrier: _____
Subscriber Name: _____
Birth Date: ___/___/___ Social Security Number: _____

Emergency Contacts:

1. _____ _____
Name Relationship Phone Number

2. _____ _____
Name Relationship Phone Number

3. _____ _____
Name Relationship Phone Number

*****Please bring your insurance card, driver's license, and copayment to every visit*****

What is the highest level of education you have completed?

- ☐ 8th grade or less
- ☐ 9-12 grade
- ☐ High school graduate
- ☐ Some college or technical school
- ☐ 4 Year college graduate
- ☐ Graduate school

What is your current employment status?

- ☐ Currently Employed
- ☐ Disabled
- ☐ Homemaker
- ☐ Retired
- ☐ Unemployed
- ☐ Student

West Michigan Rheumatology - New Patient Health Questionnaire

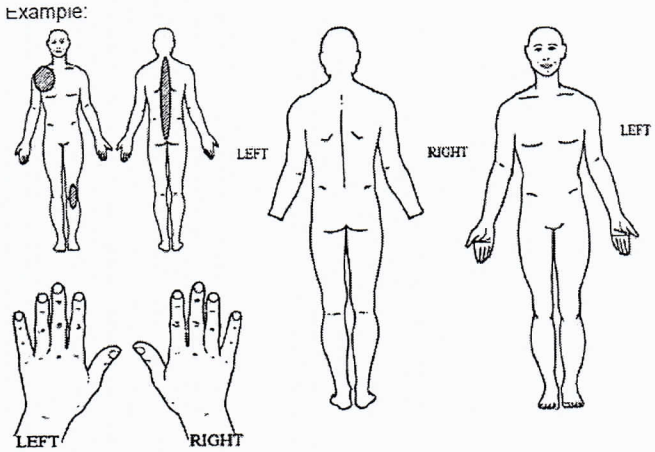
Name: _____ Age: _____ Sex: __M __F Place of Birth: _____
Last First MI

Please provide the reason that prompted **today's consultation** and briefly your main problem.

List the name and circle the type of **all doctors who have previously evaluated your current problem**:

- ☐ Dr. _____
- ☐ Dr. _____
- ☐ Dr. _____
- ☐ Dr. _____
- ☐ Dr. _____

Please shade all the locations of your pain **over the past week** on the **body figure** and **hands**.



Check the **studies that have been done to evaluate** your current problem (and location). if none check box ☐

- ☐ Laboratories
- ☐ X-rays
- ☐ CT scan
- ☐ MRI
- ☐ Biopsy
- ☐ Other

Check the **treatments that you have tried** for your current problem: if none check box ☐

- ☐ NSAIDS (ibuprofen, naproxen)
- ☐ Tramadol (Ultram)
- ☐ Norco
- ☐ Prednisone
- ☐ Joint injections
- ☐ Antidepressant
- ☐ Cymbalta (Duloxetine)
- ☐ Neurontin (Gabapentim)
- ☐ Lyrica (Pregabalin)
- ☐ Methadone/Fentanyl patch
- ☐ Morphine/ Oxycontin
- ☐ Joint Injections
- ☐ Spine Injections
- ☐ Physical Therapy
- ☐ Chiropractor
- ☐ Surgery
- ☐ Other (specify)

- ☐ Hydroxychloroquine (Plaquenil)
- ☐ Sulfasalazine (Azulfadine)
- ☐ Methotrexate (Rheumatrex)
- ☐ Leflunomide (Arava)
- ☐ Azathioprine (Imuran)
- ☐ Etanercept (Enbrel)
- ☐ Adalimumab (Humira)
- ☐ Infliximab (Remicade)
- ☐ Golimumab (Simponi)
- ☐ Certolizumab (Cimzia)
- ☐ Anakinra (Kineret)
- ☐ Abatacept (Orencia)
- ☐ Rituximab (Rituxan)
- ☐ Tocilizumab (Actemra)
- ☐ Tofacitinib (Xeljanz)
- ☐ Ustekinumab (Stelara)
- ☐ Secukinumab (Cosentyx)

Medical History

Circle any conditions a physician has diagnosed you with: if none check box ☐

Juvenile arthritis	Systemic Lupus Erythematosis	Vasculitis	Hip fracture
Rheumatoid arthritis	Scleroderma	Giant Cell Arteritis	Spinal fracture
Psoriatic Arthritis	Polymyositis	Temporal Arteritis	Osteoarthritis
Crohns Disease	Dermatomyositis	Polymyalgia Rheumatica	Fibromyalgia
Ulcerative Colitis	Sjogren's Syndrome	Wegener's granulomatosis	Gout
Ankylosing Spondylitis	Raynauds Phenomenon	Lyme disease	Pseudogout
Reiter's Syndrome	Antiphospholipid Antibody Syndrome		Osteoporosis
			Osteopenia

Psoriasis	Diabetes	Neuropathy	Drug Problem
Crohns Disease	Hypertension	Stroke or TIA	Alcohol Problem
Ulcerative Colitis	Coronary artery disease	Rheumatic Fever	Post-traumatic stress disorder
Sarcoidosis	Peripheral vascular disease	Multiple miscarriage	Depression
Liver cirrhosis	Pulmonary Embolism	COPD/ emphysema	Bipolar
Chronic kidney disease	Deep Vein Thrombosis	Seizure disorder	Schizophrenia
Stomach ulcer	Pulmonary Hypertension	Cancer	Panic Attacks
HIV/AIDS	Pulmonary / Lung Fibrosis	Hepatitis B or C	Migraines
Heart Failure / CHF	Kidney stones	Blood transfusion	

Family History Circle below if any of **your blood relatives** have had:if none check box☐

Juvenile arthritis	Systemic Lupus Erythematosis	Crohns Disease	Hip fracture in mother
Rheumatoid arthritis	other Connective Tissue Disease	Ulcerative Colitis	Osteoporosis
Psoriatic Arthritis	Recurrent blood clots	Psoriasis	
		Ankylosing Spondylitis	

Surgical History Please check any surgeriesyou have had and list year if known: if none check box ☐

- ☐ Tonsillectomy
- ☐ Appendectomy
- ☐ Thyroid or Thyroid nodule removal
- ☐ Cholecystectomy/ Gallbladder removal
- ☐ Bowel resection
- ☐ Splenectomy
- ☐ Kidney stone removal
- ☐ Coronary Bypass Graft
- ☐ Heart valve replacement
- ☐ Pacemaker
- ☐ Leg bypass graft or stent
- ☐ Vein surgery
- ☐ Mastectomy/ Breast Removal
- ☐ Hysterectomy
- ☐ Ovary removed
- ☐ Bladder repair
- ☐ Hernia
- ☐ Prostate scope (TURP)
- ☐ Prostate removal for cancer
- ☐ Cervical Laminectomy
- ☐ Lumbar Laminectomy
- ☐ Spinal fusion (specify)
- ☐ Spinal kyphoplasty (cement injection)
- ☐ Joint arthroscopy (specify)
- ☐ Joint replacement (specify)
- ☐ Fracture surgery (specify)
- ☐ Vasectomy
- ☐ Tubal Ligation
- ☐ Uterine Ablation
- ☐ Brain aneurism – clip
- ☐ Other implantable device
- ☐ Other (specify)

New Patient History Questionnaire

Medication History

List **all** medications that you are **currently** taking. (attach additional sheet if needed)

Drug name	Dose	How often		Drug name	Dose	How often
1.				6.		
2.				7.		
3.				8.		
4.				9.		
5.				10.		

Medical Allergies

Do you have drug allergies? __YES __NOPlease list the medication(s) and what type of reaction(s) were caused:

_____

_____

Social History

Do you drink alcohol?☐Yes☐No

Health Maintenance

Please list below the most recent dates of your vaccines and health tests

	Date
Flu Vaccine	
Pneumovax (Pneumonia) Vaccine	
Zostavax (Shingles) vaccine	
Tuberculosis (TB) Skin Test	