TARRANT ARTHRITIS CENTER

Thank you for choosing Tarrant Arthritis Center for your care and we look forward to your visit. Attached is the new patient paperwork that needs to be completed prior to your appointment.

**You also need to bring the following:**

- **New Patient Paperwork**
- **Picture ID**
- **Insurance Card(s)**
- **ALL of your medications, including any over the counter medications**
- **Proper Identification such as a Driver's License.**

If you were unable to complete the paperwork packet, please arrive at least 15 minutes prior to appointment time so that this can be completed.

Thank you in advance!

Tarrant Arthritis Center

Phone: 817-865-3939

Fax: 817-865-3846

TARRANT ARTHRITIS CENTER

**PATIENT REGISTRATION**

**Patient Information:** (*Please use legal name, no nickname)*

Last Name: _____First Name: _____ Middle Initial: ____

Address: _____

City: _____ State: _____Zip Code: _____

Cell Phone: _____Home Phone: _____Work Phone: _____

Social Security Number: _____

Date of Birth: _____Age: _____Sex: _____Marital Status: _____

Email Address: _____

Employer Name & Address: _____

_____

Emergency Contact Name: _____Phone number: _____

**GUARANTOR INFORMATION:** *(If different from patient)*

Last Name: _____First Name: _____Middle Initial: _____

Date of Birth: _____Social Security #: _____Relationship: _____

Employer Name: _____Phone #: _____

If you have a Personal legal Representative /Guardian who has been filling out the paperwork on your behalf, please fill out information below

Legal Representative Name _____

Legal Representative Telephone No_____

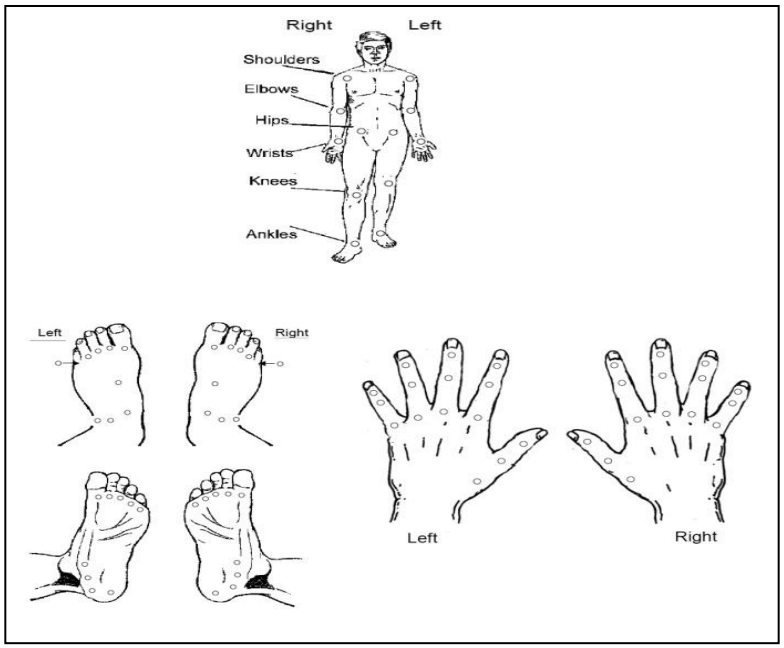
Legal Representative Signature _____

Date_____

# TARRANT ARTHRITIS CENTER

## Patient History Form

History of present Illness. Please answer each of the following 10 questions and please indicate all the locations of your pain over the past week on the body figures and hands and feet.




1. Location of the problems
   - All my joints
   - All my muscles
   - Head
   - Scalp
   - Neck
   - Right/Left Shoulder
   - Right/left elbow
   - Right/left hand
   - Upper / middle / lower back
   - Right/left hip
   - Right/left knee
   - Right/left ankle
   - Right/left feet
   - Others
2. On the scale of 1-10, with 10 being the most severe, circle the number that best describes the problem
   |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
   0 1 2 3 4 5 6 7 8 9 10
3. When did you first notice the problem? (Circle one) 2 days ago 2 weeks ago 1 month ago 1 year ago 5 years ago, Other _____
4. How long the problem lasts? (Circle one) 5-15 mins 16- 30 mins 1-2 hours always there
   Other _____
5. When is the problem the worst? (Circle One) Morning end of the day Night No relations to any specific time
   Other _____
6. Does anything make the problem worst? Y N
   If yes, moving around walking sitting standing up driving lying on my side
   Other _____
7. Does anything help or make the problem better? Y N
   If yes, please explain _____
8. Is anything else occurring at the same time? Y N
   If Yes, Nausea rash headaches fever tinging swelling stiffness
   Others _____
9. Is the problem constant or variable?
   Dull the sharp very sharp then leaves Dull then throbbing constant
   Other _____
10. Does the problem interfere with your normal functions? Y N

If yes, please explain

_____

TARRANT ARTHRITIS CENTER

**Primary Care Provider Name and Phone and fax if you have**

---

**Pharmacy: _____ Phone#:_____**

**Allergies to medications, foods, x-ray dye:**

_____ _____

_____ _____

_____ _____

**MEDICATIONS/OVER THE COUNTER MEDICATIONS/SUPPLEMENTS/HERBS*: (Bring all to your appointment)***

| Medication | Dosage | Frequency | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |

# TARRANT ARTHRITIS CENTER

Have you ever been diagnosed with Rheumatoid Arthritis? YES NO

If yes, please circle all the medications that you have taken, currently and in the past and place the date stated next to the following below

| **Oral** | **Self- injection** | **Infusion** |
|---|---|---|
| Methotrexate _____ | Adalimumab(Humira)_____ | Infliximab(Remicade)_____ |
| Hydroxychloroquine _____ | Etanercept(Enbrel)_____ | Golimumab(simponi)_____ |
| Leflunomide(Arava) _____ | Certolizumab _____ | Abatacept(Orencia)_____ |
| Azathioprine _____ | Golimumab (Simponi) _____ | Tocilizumab (Actemra)_____ |
| Sulfasalazine _____ | Abatacept(Orencia)_____ | Rituximab_____ |
| Tofacitinib(Xeljanz) _____ | | |
| Baricitinib(Olumiant) _____ | | |
| Upadacitinib(Rinvoq) _____ | | |

**PAST MEDICAL HISTORY: Please list all the disease or conditions that you are currently being treated for**

1._____ 2. _____3. _____

4. _____5. _____ 6. _____

7. _____ 8. _____9. _____

**Please check if you have a personal history of any of the following in addition to you have listed above**

___Diabetes _____High blood pressure____ High Cholesterol _____Stroke ___Cancer _Kidney disease ___Tuberculosis_____Hepatitis B_____Hepatitis C_____Diverticulosis_____Congestive Heart Failure_____Anemia_____Colitis_____Psoriasis_____Iritis/Uveitis_____Sarcoidosis_____ COPD/EmphysemaOthers_____

**PAST SURGICAL HISTORY: Please check if you have had any of the following surgeries:**

| | | | |
|---|---|---|---|
| ____Appendectomy | ____Carotid surgery | ____Hip replacement --____Right | ____Left |
| ____CABG | ____Gastric Bypass | ____Knee replacement-____Right | ____Left |
| ____Hysterectomy | ____Bariatric procedure | ____Kidney Transplant | |
| ____Prostatectomy | ____Hernia repair | ____Thyroidectomy | ____AV Fistula ____PD catheter |
| ____Nephrectomy | ____Hemorrhoidectomy | ____Tonsillectomy | ____AV Graft |

List any other surgeries or any other health problems not listed above:

# TARRANT ARTHRITIS CENTER

**Family History: Do you know of any close relative who has or had any of following medical conditions:**

Osteoarthritis: _____ Rheumatoid arthritis _____ gout_____

Systemic lupus erythematous_____ other connective disease _____

Psoriasis _____Cancer _____ Heart Disease _____

High blood pressure _____ Diabetes _____ Others _____

**Social History:**

Do you smoke? Yes No Amounts per day _____ Previous Smoker? How long ago? _____

Do you drink Alcohol? Yes No How frequent? _____ How Much?_____

Illicit Drug use: _____

**Review of System**

| | | | | | |
|---|---|---|---|---|---|
| **Constitutional** | ☐Chills | ☐Fatigue | ☐Fever | ☐Weight gain | ☐Weight loss |
| **Allergy** | ☐Itching | ☐Recurrent Infection | | ☐Sneezing | ☐Watery eyes |
| **Eyes** | ☐Blurry vision | ☐Dry eyes | ☐Eye pain | ☐Itching and redness | ☐Red eyes |
| **Ears-Nose-Mouth** | ☐Decreased hearing | | ☐Dry mouth | | ☐Ringing in the ears |
| | ☐Sore throat | | ☐Swollen glands. | | |
| **Endocrine** | ☐Excessive thirst | | | | |
| **Respiratory** | ☐Cough | | ☐Shortness of breath | | ☐Wheezing |
| **Cardiovascular** | ☐Chest pain | | ☐Irregular heartbeat | | ☐Swollen in hands/feet. |
| **Gastrointestinal** | ☐Abdominal pain | ☐Constipation | ☐Diarrhea | ☐Nausea | ☐Vomiting |
| **Hematologic/Lymphatic** | ☐Anemia | ☐Blood Clot requiring blood thinner | | ☐Easy bruising. | |
| **Urinary** | ☐Blood in urine | ☐Frequent Urination | | | |
| **Musculoskeletal** | ☐ Joint stiffness | ☐Painful joints | | ☐Weakness | |
| **Skin** | ☐Discoloration | ☐Dry Skin | ☐Hair loss | ☐Nodule | ☐Rash |
| **Neurological** | ☐Dizziness | ☐Headache | ☐Tingling/numbness in feet or hands | | ☐Tremor |
| **Psychiatry** | ☐Anxiety | ☐Depression | ☐Difficulty sleeping. | | |

TAC
Tarrant Arthritis Center

## Receipt of Notice of Private Practice

I, _____, have received the copy of Tarrant Arthritis Notice of Private Practice.

Patient Signature _____.

## Patient request regarding release of medical records

Who to contact

By completing and signing this document I hereby give permission to Tarrant Arthritis center to disclose as well as to discuss any Protected Health information related to my Health condition(s) to following people

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ I do not wish to disclose my Protected Health Information to anyone besides myself regarding my medical condition.

How to contact

Phone number_____

Patient Signature _____ Date: _____

# CONSENT FOR MEDICAL CARE AND TREATMENT

I understand that I may have a medical condition that could require examination, diagnosis and treatment and other medical services which may include x-rays, laboratory procedures, tests and medications. I do hereby voluntarily consent to such examination, diagnosis, treatment, and other medical services, and procedures that may be recommended under the general and specific instructions of the physicians of Tarrant Arthritis Center, their assistants, nurses or designees. I acknowledge that the practice of medicine is not an exact science and that the physicians of Tarrant Arthritis Center have made no guarantees to me as to the result of examination, diagnosis, treatment or other medical services.

It is the policy of Tarrant Arthritis Center to participate in or support clinical research designed to use patient data to improve diagnosis and treatment of medical illnesses and to identify potential study subjects for clinical research; such research support may include the review or disclosure of a patient's medical records to research staff unless you indicate you do not consent.

**INFORMED CONSENT FOR PRESCRIPTIONS**

Tarrant Arthritis Center continues its position as the network exchange for the flow of vital patient information to physicians and other health care providers. It is essential to improve patient safety and the continuity of care with electronic connectivity between payers, physicians and pharmacists. Tarrant Arthritis Center electronic health record (EHR) provides secure access for patients with prescription coverage in the United States.

Prescription eligibility, benefit, formulary and medication history information is provided for consenting patients to authorized physicians at the point of care. Electronic prescriptions are delivered in real-time to pharmacists in the retail and mail order settings.

I consent to electronic prescriptions and acknowledge that Tarrant Arthritis Center will use electronic connectivity between payers, physicians and pharmacists.

**PATIENT PORTAL CONSENT**

Tarrant Arthritis Center is offering the patient portal as a convenience to you. The patient portal is a secure web portal that allows you, as a patient, to view your medical chart and to access our online bill pay via the internet. It also allows you to communicate with our office via secure messaging. You may request appointments, schedule changes, and medication refills (not including controlled substances).

Tarrant Arthritis Center reserves the right to suspend or terminate the patient portal at any time and for any reason.
I understand that the patient portal will be offered at no charge and acknowledge that communications over the internet using the portal is secure. I also, agree to the policy defined herein for suspension or termination of portal access.

Signature of Patient or legal Representative _____Date_____

# TARRANT ARTHRITIS CENTER

## RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Social Security #: _____

Patients Phone #: _____

I request and authorize: _____ To release the medical record of the above-named patient to:

Name of recipient: Tarrant Arthritis Center
Address: 4375 Booth Calloway Road, suite 208, North Richland hills, TX 76180
Telephone number: 817-865-3939
Fax number: 817-865-3846

Reason for Release: Continue medical care

This request and authorization apply to: (check appropriate line)

_____Healthcare information relating to the following treatment, condition, or dates of treatment: _____

Please send Face sheet, H&P, Consultation notes, Discharge Summary, Laboratory results, and Radiology reports.

_____All healthcare information including information relating to HIV/AIDS testing, sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use.

_____ All healthcare information excluding information relating to HIV/AIDS testing, sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use.

_____

Signature of patient or authorized representative Date
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative)

Atten : ALICIA

# RAPID3

## ROUTINE ASSESSMENT OF PATIENT INDEX DATA

The RAPID3 includes a subset of core variables found in the Multi-dimensional HAQ (MD-HAQ). Page 1 of the MD-HAQ, shown here, includes an assessment of physical function (section 1), a patient global assessment (PGA) for pain (section 2), and a PGA for global health (section 3). RAPID3 scores are quickly tallied by adding subsets of the MD-HAQ as follows:

### 1. PLEASE CHECK THE ONE BEST ANSWER FOR YOUR ABILITIES AT THIS TIME:

| OVER THE LAST WEEK, WERE YOU ABLE TO: | WITHOUT ANY DIFFICULTY | WITH SOME DIFFICULTY | WITH MUCH DIFFICULTY | UNABLE TO DO |
|---|---|---|---|---|
| a. Dress yourself, including tying shoelaces and doing buttons? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| b. Get in and out of bed? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| c. Lift a full cup or glass to your mouth? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| d. Walk outdoors on flat ground? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| e. Wash and dry your entire body? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| f. Bend down to pick up clothing from the floor? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| g. Turn regular faucets on and off? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| h. Get in and out of a car, bus, train, or airplane? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| i. Walk two miles or three kilometers, if you wish? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| j. Participate in recreational activities and sports as you would like, if you wish? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| k. Get a good night's sleep? | ___ 0 | ___ 1.1 | ___ 2.2 | ___ 3.3 |
| l. Deal with feelings of anxiety or being nervous? | ___ 0 | ___ 1.1 | ___ 2.2 | ___ 3.3 |
| m. Deal with feelings of depression or feeling blue? | ___ 0 | ___ 1.1 | ___ 2.2 | ___ 3.3 |

**1. a-j FN** (0-10):

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

**2. PN** (0-10):

**3. PTGE** (0-10):

**RAPID3** (0-30)

### 2. HOW MUCH PAIN HAVE YOU HAD BECAUSE OF YOUR CONDITION OVER THE PAST WEEK? PLEASE INDICATE BELOW HOW SEVERE YOUR PAIN HAS BEEN:

NO PAIN — PAIN AS BAD AS IT COULD BE

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

### 3. CONSIDERING ALL THE WAYS IN WHICH ILLNESS AND HEALTH CONDITIONS MAY AFFECT YOU AT THIS TIME, PLEASE INDICATE BELOW HOW YOU ARE DOING:

VERY WELL — VERY POORLY

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

CONVERSION TABLE

**Near Remission (NR):** 1=0.3; 2=0.7; 3=1.0
**Low Severity (LS):** 4=1.3; 5=1.7; 6=2.0
**Moderate Severity (MS):** 7=2.3; 8=2.7; 9=3.0; 10=3.3; 11=3.7; 12=4.0
**High Severity (HS):** 13=4.3; 14=4.7; 15=5.0; 16=5.3; 17=5.7; 18=6.0; 19=6.3; 20=6.7; 21=7.0; 22=7.3; 23=7.7; 24=8.0; 25=8.3; 26=8.7; 27=9.0; 28=9.3; 29=9.7; 30=10.0