MILLENNIUM PHYSICIANS RHEUMATOLOGY –
NEW PATIENT SURVEY

Answer each line and question in the space provided. Circle/check the best answer. Fill out both sides of this form. This survey will help the doctor evaluate, diagnose and treat you. Write your comments & questions on next page.

Name:______________________________ Age:_____	Date:__________ Referred by: ______________
Birthdate: / /	My Primary Care MD:

ABOUT YOUR ARTHRITIS OR PROBLEM

What is your problem?____

Symptoms First Began: Month ______Year________ Initial Symptom(s): ___________________________

What tests were Abnormal: ☐ANA ☐Sed Rate ☐RF (rheumatoid factor) ☐Uric Acid ☐Biopsy

I am mostly concerned about:____

I am having: ☐Pain ☐Stiffness ☐Aching ☐Soreness ☐Muscle pain ☐Swelling ☐Weakness ☐Numbness

How long is your Morning Stiffness?

My Sleep is: ☐Great ☐Normal ☐Fair ☐Poor ☐Very Poor

In PAST WEEK, how much pain have you had? (circle a number or put a mark thru the line below)

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 *MOST SEVERE PAIN*

Mild *Moderate* *Severe*

WT

BP

P

R

T

____
Patient Signature

Medical History				**Past Surgeries**	**Year**
☐ Stroke ☐ TIA	☐ Skin Problems	☐ Sleep apnea	☐ Osteoporosis	☐ Neck Surgery	
☐ Neuropathy	☐ Psoriasis	☐ Osteoarthritis	☐ Fibromyalgia	☐ Back Surgery	
☐ Depression	☐ Thyroid Problem	☐ Rheumatoid arthritis	☐ Lupus	☐Joint replacmnt	
☐ Alcohol abuse	☐ Cancer	☐AnkylosingSpondylitis	☐ Gout	☐ Arthroscopic	
☐ Hypertension	☐ Lung Disease		☐ Vasculitis	☐ Tonsillectomy	
☐ Diabetes				☐ Appendctomy	
☐				☐ Gall Bladder	
				☐ Hysterectomy	
				☐ Heart Bypass	
				☐ Hernia repair	
				☐ Breast surgery	
				☐ Fracture(s)	

DO YOU HAVE?				
☐ Weight loss____lbs	☐ Skin rash/sores	☐ Eye pain	☐ Swallowing Problem	☐ Purple/blue fingers
☐ Weight gain____lbs	☐ Tight skin	☐ Ringing in ears	☐ Peptic ulcer	☐ Edema in legs/feet
☐ Fever	☐ Hair falling out	☐ Jaw Pain	☐ Diarrhea	☐ Pain on urination
☐ Weakness	☐ Abnormal nails	☐ Hearing problems	☐ Constipation	☐ Numbness
☐ Fatigue	☐ Easy Bruising	☐ Swollen glands	☐ Irritable bowel	☐ Headaches
☐ Night sweats	☐ Sore throat	☐ Poor appetite	☐ Blood in stool	☐ Dizzy spells
☐ Joint pains	☐ Sores in mouth	☐ Heartburn	☐ Cough	☐ Loss of Memory
☐ Morning stiffness	☐ Dental problems	☐ Nausea	☐ Short of Breath	☐ Anxiety
☐ Pain in muscles	☐ Dry mouth	☐ Vomiting		☐ Depression
☐ Back Pain	☐ Dry eyes			☐ Difficulty sleeping

Work / Lifestyle / Family / Habits / Exercise

Marital Status: ☐Single ☐Married ☐Divorced ☐ Widowed

Who lives with you?________________________ How many Kids ?________

Do you have help at home? ☐ No ☐ Yes → Who:______________________

Current Job? ________________________ Employer ________________

Do you Smoke? ☐ Never ☐No (Quit ___yrs ago) ☐Yes → (Packs per day?__)

Do you drink alcohol? ☐Never ☐I quit ☐Rarely ☐Socially ☐Daily (________)

Have you used illegal drugs? ☐ Never ☐ Yes (Which ______________________)

My Family History

	Mother	Father	Brother	Sister
Alive? (Y/N)				
Age				
Heart attack				
Diabetes				
Hypertension				
Stroke				
Cancer/type				
Arthritis/type				

What else do you want the Doctor to know: ____

____

____

____

Nurse Notes: ____

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Rheumatology

NEW PATIENT MEDICAL QUESTIONNAIRE – RHEUMATOLOGY

Please complete this questionnaire by answering each question as accurately as possible.

GENERAL INFORMATION

Patient Name:______________________ Date of Birth:____________ Social Security:_____-_____-_____

Phone #: (___)_____-______ Cell #: (___)_____-______ Address: ______________________

Primary Care Physician:______________________ Referring Physician: ______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Other______________

CHIEF COMPLAINT/REASON FOR VISIT

What is the reason for your visit today? ______________________

Are you experiencing any pain? (circle one) **YES** **NO** , if yes where is the pain location ______________

If you marked yes, please indicate on the scale of 1 to 10 with 10 being the highest, what is your level of pain:____________

MEDICATIONS

Please list all prescriptions and over-the-counter medication you take on a regular basis. **(If you have a list readily available, please give copy to the front desk)**

Medication Name	Dose (ex. 50mg)	Frequency (ex. once a day)	Reason for Taking

ALLERGIES

Are you allergic to any medications? ☐ **YES** ☐ **NO** If yes please list medications ______________

Are you allergic to intravenous contrast? ☐ **YES** ☐ **NO** If yes please list your reaction______________

Any other allergies? Incl. Latex ☐ **YES** ☐ **NO** If yes please list______________

PHARMACY INFORMATION

NAME AND NUMBER OF LOCAL PHARMACY: ______________________

NAME AND NUMBER OF MAIL ORDER PHARMACY: ______________________

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ADVANCE DIRECTIVES
CONFIRMATION FORM

Under Texas law you have the right to make decisions concerning your healthcare. The rights include the right to accept or refuse medical treatment and the right to create advance directives to make preferences about your medical care. In the state of Texas any person age 18 years or old who is legally competent has the right to make these decisions in advance.

Advance directives recognized in Texas are the Texas Durable Medical Power of Attorney, a Living Will, and an Out of Hospital Do Not Resuscitate. No patient can be discriminated against for exercising their right to elect and create advance directives.

Advance Healthcare Directives Confirmation:

☐ **YES**, I have an Advance Healthcare Directives *(select which advance directive you have below).*

- ☐ Texas Durable Medical Power of Attorney
- ☐ Living Will, officially known as the Directive to Physicians and Family or Surrogates
- ☐ Out of Hospital Do Not Resuscitate (DNR)

If you have selected YES, please provide a copy of your advance directive to the front office staff.

☐ **NO**, I do not have Advance Healthcare Directives *(select which advance directive you have below).* I understand that I can request more information about advance directives.

- ☐ I have received the information sheet about advance directives.
- ☐ I would like additional information about the three advance directives recognized in Texas.

______________________________ Patient Name (Print)

______________________________ Patient Signature Date

For Millennium Physicians Use Only

Complete this section, if this form is not signed and dated by the patient

☐ Patient refused to sign

☐ Patient unable to sign

______________________________ Employee Name

______________ Date

Millennium Physicians
Rheumatology

PATIENT ONLINE PORTAL

Millennium Physicians has a Patient Portal you can access online, portal access is free to all Millennium Physician patients.

The Patient Portal is an online tool you can use to easily view and update some of your health/clinical information

Over the next few months we will be rolling out additional access on the portal that you can utilize such as:

- Appointment Requests
- Reminders
- Prescription Refill Requests
- Communicating Non-Emergent Questions

The Patient Portal should not be used for emergency questions, concerns, or anything that needs a same day response; for all those inquires please contact the office you are seen at.

To gain access to the Patient Portal your email address is required to enroll you; if you would like access please complete the bottom section of this form.

Please check one selection:

☐ I would like to be enrolled with Millennium Physicians Patient Portal.

My email address is____(please print)

☐ I wish **NOT** to enroll for the Millennium Physicians Patient Portal because:

☐ I don't have an email address.

or

☐ I decline enrollment and do not want to provide my email address.

____________________ ____________________ __________

Patient Signature **Print Name** **Date**

DOB / /

Millennium Physicians
Rheumatology

GENERAL CONSENT FOR TREATMENT AND ACKNOWLEDGEMENT

MEDICAL CONSENT: I consent to all medical care, treatment, laboratory, imaging and other medical procedures performed or prescribed by a physician of Millennium Physicians and his/her designees as directed in his/her judgement.

RIGHT TO REFUSE TREATEMENT: I understand that I have the right to make informed decisions regarding all my care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatments that I do not want.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS & NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received both notices, Notice of Patient Rights/Responsibilities and Notice of Privacy Practices.

ADVANCE DIRECTIVES: I understand that I have an opportunity to make known my wishes, in writing regarding my health care and/or end of life decisions. This directive is in the form of a living will and/or durable power of attorney for health care.

RELEASE OF MEDICAL INFORMATION: I authorize Millennium Physicians Association, PLLC to release any information necessary to facilitate healthcare processing of claims, and audit of payments relative to my care/treatment with Millennium Physicians. I also consent to the release of any information as needed for my care to other facilities, agencies, or healthcare providers as I direct or as required by law. This order will remain in effect until revoked by me in writing.

FINANCIAL AGREEMENT: I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists. I understand I am financially responsible to Millennium Physicians for charges not paid under this agreement. I am responsible for all charges for services provided to me which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. Millennium Physicians will make every attempt to notify me in advance if a service is not covered. I agree to pay all applicable co-payments, deductibles, and co-insurance. I am responsible to pay all copays, deductibles, and patient responsibility at the time of service unless other arrangements have been made in advance.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medigap, Medicare Replacement, private insurance and any other health / medical plan, to issue payment check(s) directly to **Millennium Physicians Association, PLLC** for medical services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorized any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (Consent applies only when applicable.)

By signing below, I acknowledge that I have read, understand, and agree to the terms and conditions of this form and that I am authorized as the patient or the Patient's Legal Representative to sign this document.

______________________	______________________	__________
Patient /Legal Representative Name (Print)	Patient/Legal Representative Signature	Date

For Millennium Physicians Use Only

Complete this section, if this form is not signed and dated by the patient or patient's legal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Millennium Physicians Notice of Privacy Practices but was unable to do so for the following reason:

☐ Patient refused to sign ☐ Patient unable to sign ☐ Other Reason (Describe):______________________

______________________ __________
Employee Name Date

Millennium Physicians
Rheumatology

PATIENT AUTHORIZATION
TO COMMUNICATE AND DISCLOSE PROTECTED HEALTH INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I wish to be contacted in the following manner *(Check All That Apply):*

☐ **Home Telephone**
- ☐ Leave message with detailed information.
- ☐ Only leave message with call back details.

☐ **Work Telephone**
- ☐ Leave message with detailed information.
- ☐ Only leave message with call back details.

☐ **Cell Telephone**
- ☐ Leave message with detailed information.
- ☐ Only leave message with call back details.

☐ **Written Correspondence**
- ☐ Mail to my home address on file.
- ☐ Mail to my work/office address:

____
____

I hereby authorize one or all of the designated parties below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or any information in my medical records. I understand that the identity of designees must be verified before release of PHI.

Authorized Designees:

Name:____________________________ Relationship:____________________________ Telephone: (____)_____-______

Name:____________________________ Relationship:____________________________ Telephone: (____)_____-______

Name:____________________________ Relationship:____________________________ Telephone: (____)_____-______

Name:____________________________ Relationship:____________________________ Telephone: (____)_____-______

This authorization shall remain in effect from the date signed below until revoked.
You have the right to revoke this authorization in writing.

- ***I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.***
- ***I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.***

______________________________ ______________________________ ____________
Patient/Legal Representative Print Name Patient/Legal Representative Signature Date

☐ **REVOKE/CANCEL THIS AUTHORIZATION** ______________________________ ____________
Patient/Legal Representative Signature Date

Millennium Physicians
Rheumatology

RHEUMATOLOGY NO SHOW AND CANCELLATION POLICY

Cancellation of an Appointment

If you are unable to make your appointment, we ask that you please call promptly to cancel as soon as possible so that we are able to meet medical needs of our community.

Once cancelled, your appointment time will then be offered to another patient who is in urgent need of treatment.

If it is necessary to cancel your scheduled appointment, we require a 24-hour business hour notice in advance of the appointment time.

As an example, if your appointment is scheduled on Tuesday at 3 PM, please call prior to 3 PM on Monday. Monday appointments should be cancelled by Friday if possible. Appointments are in high demand, so it is very helpful to use every appointment time for a patient in need.

Our physicians appreciate your help to make this possible.

How to cancel your appointment

To cancel your appointment, please call 281-315-8130

Late Cancellations

Same day cancellations are considered as a "No Show" appointment

No Show

A "No Show" is a patient who misses an appointment without cancelling it 24 business hours in advance of the scheduled appointment. Failure to be present at the time of scheduled appointment, or to call 24 hours in advance to cancel, will be recorded in your chart as "No Show". A fee of $50 will be applied to your account as follows:

$50.00 1st no-show
$75.00 Subsequent occurrences

These fees cover the administrative tasks associated with your appointment, which still incur even when you have not seen the doctor. Payment in full of this fee is required before scheduling any further appointments. A patient with a third no show in a 12-month period will be considered for discharge from the practice.

Patient Signature: ______________________ DOB __/__/__ Date: ______________

Millennium Physicians
Rheumatology

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:____ Date of Birth:____________________

Address:____Telephone: (_____)_____-______

I hereby authorize:

______________________________	______________________________	______________________________
Name of Provider/Hospital/Physician	Provider/Hospital/Physician Address	Telephone Number

To release the following information from my health record covering the period of From______________ to____________, if I do not specify a period I am authorizing the release of records for entire duration of care with the provider. *(check all that apply below)*

☐ Complete Medical Record (includes information regarding insurance, demographic, referral documents, and medical Records). ***If this box is checked, do not check any additional boxes.***

☐ Progress/Office Visit Notes ☐ Radiology/Imaging Reports ☐ Chemotherapy/Radiation Records

☐ Lab Reports ☐ Pathology Reports ☐ Billing/Payment Records

Information is to be released to:
Millennium Physicians - Rheumatology
Address: ____
Telephone: _____________________________________Fax : ______________________________________

The information is being released for the following purposes:

☐ Continued Care/Treatment ☐ Disability ☐ Attorney/Litigation ☐ Other__________________

I understand that this authorization will remain in effect until I revoke it in writing.
I understand that according to applicable state and or/federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment

______________________________	______________________________	____________
Patient/Legal Representative Print Name	Patient/Legal Representative Signature	Date

☐ **REVOKE/CANCEL THIS AUTHORIZATION** ______________________________ ____________
Patient/Legal Representative Signature Date

PATIENT AGREEMENT FOR LONG-TERM OPIOID THERAPY

Best Practices require signed Opioid agreement to be on file for all Schedule 2 drugs, including but not limited to the following:

* Morphine * Meperidine (Demerol) * Methamphetamine * Hydrocodone (Norco) * Fentanyl * Adderall * Hyrdomorphone (Dilaudid) * Methadone * Ritalin * Oxycodone (OxyContin, Percocet)

1. I, , agree that Anil Warrier (Rheumatology) will be the only physician prescribing OPIOID (also known as NARCOTIC) pain medication for me and that I will obtain all of my prescriptions for opioids at one pharmacy. The exception would be an emergency situation or in the unlikely event that I run out of medication. Should such occasions occur, I will inform my physician as soon as possible.

2. I will take the medication at the dose and frequency prescribed by my physician. I agree not to increase the dose of opioid without first discussing it with my physician. I will not request earlier prescription refills.

3. I will attend all reasonable appointments, treatments and consultations as requested by my physician. I agree to other pain consultations/management strategies as necessary.

4. I understand that the common side effects of opioid therapy include nausea, constipation, sweating and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.

5. I understand that using long-term opioids to treat chronic pain may result in the development of a physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of opioid withdrawal. I understand that opioid withdrawal is uncomfortable but not life threatening.

6. I understand that there is a small risk that I may become addicted to the opioids I am being prescribed. As such, my physician may require that I have blood, urine or hair testing and/or see a specialist in addiction medicine should a concern about addiction arise.

7. I understand that the use of a mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician.

8. I understand that I should check with my physician or pharmacist before taking other medications including over-the-counter and herbal products.

9. I agree to be responsible for the secure storage of my medication at all times. I agree not to give or sell my prescribed medication to any other person. Depending on the circumstances, lost medication may not be replaced until the next regular renewal date.

10. I consent to open communication between my doctor and any other health care professionals involved in my pain management, such as pharmacists, other doctors, emergency departments, etc. I consent to open communication between my doctor and any other health care professionals involved in my pain management, such as pharmacists, other doctors, emergency departments, etc.

11. I understand that if I break this agreement, my physician reserves the right to stop prescribing opioid medications for me.

Date:

______________________________ DOB / / ________

(Signature - Patient)

Anil Warrier (Rheumatology)

____

(Signature Physician)