Paducah Rheumatology

100 Kiana Court Ste B, Paducah, KY 42001

It is a pleasure to welcome you to our office. Complete both sides of this form to aid us in preparing or updating your clinical records. All information provided to us will be strictly confidential. Please have your insurance card(s) available at your appointment in order to make copies. This office will process your primary insurance and provide information to you for any additional insurance.

Today's Date: ______________________ Referred to this office by: ______________________________________

____ Mr. ____ Ms. ____ Mrs. First: ______________________ M: ________ Last: ______________________

Address: ______________________________ City: ________________ State: ________ Zip: __________

Birthdate: _____/_____/_____ Age: ______ Sex: Male / Female Social Security # ______-_____-__________

Phone #'s: Home: ____________________ Work: ______________________ Cell: _____________________

Marital Status: _____________ Employment: _____ Fulltime _____Part Time _____Retired _____ Disabled _____ Student

Occupation/Job Title: ________________________________ Employer: ________________________________

Employer Address: ____ Phone: __________________

Spouse's Name: ______________________________ SS#: __________________ DOB: ______________

Spouse's Employer: ________________________ Employer Address & Phone:____________________________

Primary Insurance: ______________________ Secondary Insurance: ______________________________________

Emergency Contact: ________________________________ Phone: ________________________

Relationship: _____________ Address: ____

Pharmacy: _______________ Address: __________________________________ Phone #: __________________

I understand I am responsible for all charges that result from services rendered to me by the physician of **Paducah Rheumatology**. I hereby authorize payment to be made directly to me or in the case of assignment to the **Paducah Rheumatology** physician rendering services. I also authorize release of pertinent medical information to the insurance carrier.

____ ____________________________________

(Guarantor's Signature) (Date)

Reason for today's visit: ____

____

Medications (include vitamins & supplements) ☐ Separate medication list attached	**Dosage**	**For What Condition?**

Allergies (medication & non-medication)	**Reaction(s)**

Medical Conditions	**Surgeries**

Family History: (List all family health issues)	______ Family History unknown

Mother: Living / Deceased (age/cause of death): ____________________________
Arthritis (type): ____________________ Diabetes High Blood Pressure
Autoimmune Disease (type): ____________________Heart Disease Other: ____________________
Father: Living / Deceased (age/cause of death): ____________________________
Arthritis (type): ____________________ Diabetes High Blood Pressure
Autoimmune Disease (type): ____________________ Heart Disease Other: ____________________
Brothers: (number of) ______________ **Sisters**: (number of) ______________
Arthritis (type): ____________________ Diabetes High Blood Pressure
Autoimmune Disease(type): ____________________ Heart Disease Other: ____________________
Children:(number of)______________Commets:____________________________

Social History: Mark ***all*** that applies
Tobacco: Do you currently use tobacco of any type? (Cigars, cigarettes, pipe, chew)

- If **Yes**, how much do you smoke?: #____ pk/per ____ Day **or** ____ Chew: # cans/per ____ Day
- If **No**, have you **ever** been a smoke? ____ Yes (former smoker) ____ No (never smoker)

Alcohol: ____ I do **not** drink alcohol ____ social consumption ____ daily consumption *How much per week?* ____