FLORAL PARK ARTHRITIS, P.C. Today's Date: _____

Last Name:_____**First Name:**_____

Date of Birth:_____**Social Security #:** _____**Gender:** ( )Male, ( )Female

Address:_____

City:_____**State:**_____**Zip:**_____**Apt#:**_____

Telephone # (home):_____**(work):**_____**(cell):**_____

Email Address:

Race: ( )African American, ( )Asian, ( )White, ( )Other _____**Ethnicity**: ( )Hispanic, ( )Non-Hispanic
Language: ( )English, ( )Spanish, ( )Other_____ **Refuses to Report/Unreported:**( )
Marital Status: ( )Divorced, ( )Married, ( ) Separated, ( ) Single, ( )Widowed

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Pharmacy: _____ **Tel #:**_____**Fax#:**_____

Address:

Employer Name/Address: _____

Primary Insurance:_____ **ID#**_____
Insured Name:_____**Relationship:**_____

Secondary Insurance:_____**ID#**_____
Insured Name:_____**Relationship:**_____

Workers' Compensation Case #:_____ **No Fault Case #:**_____
Is this condition related to an accident?: **Date of occurrence:**

Referring Doctor:_____**Telephone:**_____

Address:

Spouse's Name:_____**Date of Birth:** _____
Address:_____**Social Security #:**_____
Employer Name/Address:

Emergency Contact: **Telephone #:**

I AUTHORIZE USE OF MY SIGNATURE ON ALL OF MY INSURANCE SUBMISSIONS. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED. I ALSO AUTHORIZE PAYMENT TO BE MADE TO THE PHYSCIAN.

Signature:_____
I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL

I HEREBY CONFIRM THAT I HAVE RECEIVED A COPY OF HIPPA NOTICE OF PRIVACY PRACTICE FROM FLORAL PARK ARTHRITIS, P.C. AND AGREE TO ITS CONTENT.

Signature: _____**Date:**_____

CHIEF COMPLAINT: _____ Onset Date:_____

Location of pain: _____ Severity: ( )Mild, ( )Moderate, ( )Severe

How long does it last? (Minutes/Hours): _____Type of Pain: ( )Burning, ( )Sharp, ( )Dull, ( )Achy

Modifying Factors: (Worsens or improves with what position or activity):_____

Are there other Associated Symptoms? (Change of strength, sensation, vision, speech, NONE, or other):

_____

REVIEW OF SYSTEMS: Do you have problems with? (Please circle all that apply)

Weight loss/gain	Fatigue	Fever	Weakness	Skin
Ears/ Nose/ Throat	Head/ Neck	Eyes/ Vision	Heart	Breathing
Gastro/ Stomach	Muscle Pain	Joint Pain	Joint Swelling	Joint Weakness
Numbness	Anxiety/ Depression	Generalized Pain	None	Other:

PAST MEDICAL HISTORY: Do you have? (Please circle all that apply)

Diabetes	Thyroid Disease	Heart Disease	Cancer	Hypertension	High Cholesterol
Stroke	Psychiatric Dis.	Asthma	Carpal Tunnel	Fibromyalgia	Gout
Systemic Lupus	Osteoarthritis	Osteoporosis	Psoriatic Arthr	Rheumatoid Arthr	Lyme Disease

Current Medication: (Including Non-Prescription, Vitamins, Herbs)_____
_____
_____

Past Surgical History: _____

Past Hospitalizations: (Date, Illness) _____

Allergies to Medications, Food, Contrast Dye, or NONE _____

Family History: Are your parents alive? _____

(If they are not, please provide details of illness, etc) _____

Is there a family history of: (Please state RELATION in space provided)

Hypertension:	Osteoarthritis:	Osteoporosis:
Gout:	Muscle Weakness:	Systemic Lupus:
Diabetes:	Psoriasis:	Rheumatoid Arthritis:
Other Rheumatic Conditions:		

SOCIAL HISTORY: Have you ever used? ( )Tobacco, ( )Alcohol, ( )Recreational Drugs
If yes to any of the above, please clarify: _____

Do you have risk factors for HIV: ( )Yes, ( )No