PATIENT REGISTRATION **DATE**_____

Patient Name_____Sex_____Age____Birthdate___/___/_____

Social Security Number_____Married_____Single_____Divorced_____Other_____

Street Address_____Apt#_____City_____State____Zip Code_____

Home phone_____ Cell phone_____ Mailing Address (if different) _____

Your Employer_____ Work phone_____

Business Address_____ Present Position_____

IF CHILD: Parent's name_____ Parent's Social Security #_____Birthdate_____

Ethnicity (optional) White: _____ Hispanic: ____ African American: ____ Asian: _____ other: _____

Email address (for patient portal) _____

PERSON RESPONSIBLE FOR THE ACCOUNT_____

SPOUSE'S NAME_____ Social security # (if the patient is the spouse of the insured__

_____Birthdate____/____/_____**SPOUSE EMPLOYER**_____

Work phone_____ Business address_____

PURPOSE OF THE APPOINTMENT_____

Whom may we thank for referring you?

_____Phone:_____

HEALTH INFORMATION

Name of the Primary Care Physician: _____Phone number_____

Please list all medication you are presently taking (including vitamins and over-the counter medications)

_____

_____

_____

_____

If female, are you pregnant?_____Due Date_____Date of last Dental Exam_____

Have you ever received the following vaccinations (please list the date if known): Influenza ("flu shot")_____

_____Pneumococcal vaccine ("pneumonia shot")_____Zoster vaccine_____

_____

ALLERGIES: Penicillin_____Anesthetic_____Latex_____Other_____

_____

DO YOU HAVE OR HAVE YOU EVER HAD (please encircle all that apply if not named please write below)

High blood pressure; Low blood pressure; Diabetes mellitus; Kidney disease; Liver disease; Lung disease; Heart disease; Rheumatic fever; Heart murmur; Cancer; Radiation treatment; Asthma; Bronchitis; Frequent sinus infections; Pneumonia; Tuberculosis; Hepatitis; Kidney infections; Sexually transmitted diseases; Herpes; Zoster (shingles); HIV/AIDS; Infections during or after travel; Urinary tract infections; Anemia; Abnormal bleeding; Lupus; Rheumatoid arthritis.

HAVE YOU EVER HAD ANY SURGERIES? If yes, please list them below: _____

_____

_____

_____

Do you have any artificial joint/limb? _____

Do you smoke? YES/NO Have you ever smoked? YES/NO If yes, when did you stop? _____ Do you consume alcoholic beverages? _____Do you have pets? YES/NO If yes what type of pet? _____Have you ever traveled outside US? YES/NO If yes where have you traveled to:

_____

Has anyone in your family ever had: Tuberculosis YES/NO Unusual Infections: Yes/No if yes which one?

_____

Please provide preferred pharmacy:

Name:_____ Address:_____ Phone(__)_____

PLEASE LIST ANY OTHER HEALTH INFORMATION THIS OFFICE NEEDS TO KNOWTO PROVIDE OPTIMUM CARE:

_____

_____

_____

SIGNATURE_____**DATE**_____

Center for Rheumatology & Arthritis Care
902 Frostwood Dr suite 155
Houston TX 77024
Scheduleoffice155@gmail.com

Symptoms

General/Constitutional:

Fatigue/fever/ change in appetite/weight loss.

Ophthalmologic

Blurred vision/ itching and redness of the eyelid/ dry eye/eye pain/floaters in the visual field.

ENT

Nasal Ulcers/dry mouth/difficulty swallowing/sore throat.

Respiratory

Chest pain/cough/shortness of breath at rest/shortness of breath with exertion.

Cardiovascular

Chest pain at rest/chest pain with exertion/claudication/cyanosis/dyspnea on exertion/orthopnea/palpitations

Gastrointestinal

Abdominal pain/change in bowel habits/nausea/vomiting/diarrhea/blood in stool.

Genitourinary

Blood in the urine/difficulty urinating/frequent urination/painful urination.

Skin

Rash/photosensitivity/Purple hands

Neurologic

headache/ dizziness/seizures.

Musculoskeletal

Joint pain/Joint Swelling

Other Please Describe:

Patient Name: _____

Date: _____

Dr. John I. Gomez , MD, FACP FACR
Email:scheduleoffice155@gmail.com

902 Frostwood Drive Suite 155 | Houston, TX 77024
Phone: (832)530-4159 | Fax: (713)467-6389 | http://houstonrheumatologycare.com/

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

Previous Name: Social Security #:

I hereby authorize the transfer /receipt of the following healthcare information: To: John I Gomez M.D/

Fax (713)467-6389

From:_____

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

○ All healthcare information ◉ Other

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. This revocation must be in writing and delivered to the Center for Rheumatology and Arthritis Care. It is further understood that the information released is for the specific purpose stated above and may not be subject to re-disclosure by the recipient and is no longer protected.

Consent will expire 180 days after the date of signature.

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date: _____

CENTER FOR RHEUMATOLOGY AND ARTHRITIS CARE
902 FROSTWOOD DR SUITE 155
HOUSTON, TX 77024
PHONE: 832-530-4159 FAX: 713-467-6389
SCHEDULEOFFICE155@GMAIL.COM

Authorization for release of my PHI I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

1. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

2. This authorization shall be in force and effect for 180 days.

3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____
Patient Signature

Center for Rheumatology and Arthritis Care
John I Gomez MD, FACP FACR
Board Certified Rheumatology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.

Other (Please provide specific details)

_____

_____

_____ _____

Employee signature Date