
**Dr. Kenneth G. Lawlor DO**

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## Patient Information

**Today's Date: _____**

Name: _____ Date of Birth: _____ Age: _____ Sex: M / F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient SS#:_____

Patient employer/address: _____

Primary Care Physician_____ Referring Physician_____

Who to contact in case of emergency_____ Phone#:_____

Secondary emergency contact: _____ Phone #:_____

**Primary insurance** _____ _____

ID#_____ Group #_____

Primary Policy Holder Name: _____ DOB: _____

SS#_____

Policy Holder's employer/address: _____

Relationship to patient: Self Spouse Parent Guardian

**Secondary insurance** _____

ID#_____ Group #_____

Secondary Policy Holder Name: _____ DOB: _____SS#_____

Policy Holder's employer/address: _____

Relationship to patient: Self Spouse Parent Guardian

*****Reason for this visit**:* _____ _____

Date symptoms first appeared: _____ Were you injured on the job? Yes No

Do you have an Advance Directive/Living Will? Yes No

Preferred Pharmacy_____ Language_____

Preferred Lab_____ Race_____

Ethnicity_____

Who may receive information regarding your Protected Health Information? (Check all that apply)

Name: _____ Date of Birth: _____ Relation: _____

Name:_____ Date of Birth:_____ Relation:_____

May we leave messages regarding test results and appointments on your answering machine? (Check all that apply)

HOME _____ YES _____ NO

CELL _____ YES _____ NO

EMAIL ADDRESS _____

What is your preferred method of contact? _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have received, read and understand your Notice of Information Practices containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions. I authorize the above persons to receive my Protected Health Information. This agreement/consent will remain in effect unless revoked by me in writing.

Signed: _____ Date: _____

**INSURANCE AUTHORIZATION**

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**: I hereby authorize Dr. Lawlor to release any records pertaining to my treatment to my insurance company or third parties responsible for payment of my medical charges, including to review activities related to my physician's participation with my health plan.

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** I hereby authorize Dr. Kenneth Lawlor to release any information required in the course of my examination or treatment which shall include HIV, Communicable Disease, or drug abuse information.

**AUTHORIZATION TO PAY**: I request that payment, under my current insurance program, be made either to me or on my behalf to Dr. Kenneth Lawlor for any services furnished me by said physician. I understand that I am financially responsible for all charges not covered by my insurance company, insurance denials, and all services rendered without a referral or prior authorization if my plan requires one for services rendered. I agree to immediately pay all statements received by Prescott Rheumatology for services rendered. I agree to pay interest on all past due accounts (over 30 days) at the rate of 1.5% per month/18%per annum. If it becomes necessary to turn my account over to a collection agency, I agree to pay a $200 collection fee and any applicable attorney costs, in addition to the rendered services charges.

**PAYMENT POLICY:** As part of our commitment to commitment to offer medical and professional care to you, we would like to present our payment policy in order to minimize misunderstandings about our fees. Our fees and methods of payments are comparable with other medical practices in the Prescott area. We ask for payment at the time of service. We require payment of co-pays at the time of check-in.

**Signed: _____ Date: _____**

**NO SHOW POLICY**

A $75 charge will be applied to all missed appointments when our office is not given a twenty-four (24) hour notice. After three (3) missed appointments we may dismiss you for the practice.

**Signed: _____ Date: _____**

**Social and Medical History**

***Patients: Please complete both pages…Thank you!***

**Social History:**

Marital Status: ❑Single ❑Married ❑Widower ❑Separated ❑Divorced ❑Life partner

Current Occupation: _____❑Unemployed

Past Occupations: _____

Lifestyles: ❑Alcohol use: ❑IV drug use ❑other drug use ❑Tattoos ❑History of blood transfusion

❑Tobacco use: _____packs/day for _____years

Activity Level:

❑ Sedentary ❑ Moderate ❑ High/Laborer Number of days per week exercising 20+ minutes _____

**Rheumatology/Arthritis Family History (Name the conditions, if known)**

Mother_____ Sister_____

Father_____ Brother_____

Other_____

**Past Medical History:**

Has a doctor diagnosed you with any of the following conditions? Check if "yes"

Comments/Other Past Medical History?

| | | |
|---|---|---|
| | Acid Reflux/GERD | **Serious Injuries/Fractures** |
| | Anemia | |
| | Anxiety | |
| | Asthma | |
| | Bowel disease | |
| | Cancer | |
| | Crohns Disease | |
| | Depression | **Past Surgeries or Operations & Dates** |
| | Diabetes | |
| | Diverticulitis | |
| | DVT (Blood clot in the legs) | |
| | Emphysema | |
| | Headaches/migraines | |
| | Heart attack, heart disease | |
| | High blood pressure | **Past Hospitalizations & Dates (other than surgeries)** |
| | High cholesterol | |
| | HIV/Aids | |
| | Kidney Disease | |
| | Liver Disease | |
| | PE (Blood clots in the lungs) | |
| | Pneumonia | |
| | Psoriasis | |
| | Seizure | |
| | Sinusitis | |
| | Sleep problems/sleep apnea | |
| | Stomach ulcers/bleeding | |
| | Stroke/mini stroke | |
| | STD | |
| | Thyroid disease | |
| | Tuberculosis | |
| | Ulcerative Colitis | |

**PATIENT RHEUMATOLOGIC HISTORY:**

Check any of the following rheumatologic disease that you have been diagnosed with and add dates:

| | | | |
|---|---|---|---|
| | Antiphospholipid syndrome(APS) | | Periph. Nerve-Carpal Tunnel Syndrome |
| | Avascular necrosis | | Polymyalgia rheumatic |
| | Bursitis | | Polymyositis |
| | Dermatomyositis | | Pseudogout |
| | Fibromyalgia | | Psoriatic Arthritis |
| | Fracture, vertebral or other | | Reactive Arthritis (Reiters) |
| | Gout | | Rheumatoid Arthritis |
| | Hepatitis C | | Scleroderma |
| | Lupus | | Sjogren's syndrome |
| | Osteoarthritis | | Vasculitis |
| | Osteoporosis | | Other (specify) |

**REVIEW OF SYMPTONS:** Do you have problems with any of the symptoms listed below? Mark those that apply.

| | | | | | |
|---|---|---|---|---|---|
| GENERAL | | GENITAL/URINARY TRACK | | NERVOUS SYSTEM | |
| Chills | | Discharge | | Bowel/bladder control | |
| Fatigue/tiredness | | Painful urination | | Headache | |
| Fevers | | Frequency | | Numbness/tingling | |
| Night sweats | | Genital ulcer | | Other | |
| Sleep disturbance | | Blood in urine | | OBGYN | |
| Weight gain | | Testicular pain | | Abnormal menses | |
| Weight loss | | Other | | Menopause | |
| Other | | EYES/EARS/NOSE/THROAT | | Other | |
| ALLERGY | | Diminished vision | | LUNGS | |
| Seasonal | | Eye pain | | Cough | |
| Other | | Dry eye | | Coughing blood | |
| HEART | | Red eyes | | Shortness of breath | |
| Chest pain | | TMJ symptom | | Other | |
| Leg swelling | | Dry mouth | | SKIN | |
| Palpitation | | Oral ulcers | | Hair loss | |
| Other | | Parotid gland swelling | | Bruising | |
| HORMONE PROBLEMS | | Imbalance | | Sun-sensitive skin rash | |
| Thyroid | | Hearing loss | | Rash | |
| Other | | Other | | Raynaud's | |
| STOMACH/BOWEL | | BLOOD DISORDERS | | Skin disorders | |
| Anorexia | | Bleeding problems | | Other | |
| Bloody/tarry stools | | Blood transfusion | | PSYCHIATRIC | |
| Constipation | | Other | | Depression | |
| Diarrhea | | MUSCULARSKELETAL | | Anxiety | |
| Heartburn | | Joint pain | | Other | |
| Jaundice | | Joint swelling | | Notes | |
| Stomach upset | | Muscle weakness | | | |
| Nausea | | Morning stiffness≥1 hour | | | |
| Vomiting | | If "Y" _____hrs _____mins | | | |
| Other | | Muscle pain | | | |
| | | Gelling | | | |
| | | Other | | | |

| | |
|---|---|
| **List all known allergies:** | |

# MEDICATION LIST

| Name: | Date: |
|---|---|
| DOB: | Preferred Pharmacy: |

| Medication: | | Dose: | Route: | Frequency: | Approximate Start Date: |
|---|---|---|---|---|---|
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