Coastal Rheumatology Associates

A member of Southeastern Rheumatology Alliance, LLC

Coastal Rheumatology – Savannah	Coastal Rheumatology – Bluffton	Coastal Rheumatology – Statesboro
5400 Waters Ave. Savannah, GA 31404 Office: (912) 349-4227 Fax: (912) 349-4457	23 Plantation Park Drive, Suite 101 Bluffton, SC 29909 Office: (843) 815-6555 Fax: (843) 815-6553	110 Rushing Lane, Suite B Statesboro, GA 30458 Office: (912) 209-9850 Fax: (912) 209-9875

We are looking forward to seeing you on this date: ____________________ at this time: ________________ at our ______________________________ location.

You are scheduled with:

☐ Dean Stephens, M.D. ☐ Charles Degenhardt, M.D. ☐ Sarah Tarplin, M.D.

☐ Gustavo Carbone, M.D. ☐ Elizabeth Antoon, PA ☐ Vanessa Thomas, PA

☐ Cindi Boderman, NP ☐ Trevor Brown, PA ☐ Brandi Alsup, NP

We are delighted that you have chosen us for your medical needs. At Coastal Rheumatology, we take great pride in the relationships that we establish with our patients, and the ability to provide a personalized approach to difficult problems.

As a patient of Coastal Rheumatology, we appreciate you following the guidelines of the practice to help us maintain our goals. Please read through our policies carefully and call us with any questions.

New patients:

Please arrive 15 minutes before your scheduled appointment time with the completed paperwork to allow for the registration process. Please do not mail paperwork.

- There is a $25 no-show and cancelation fee for all appointments not kept or not canceled within 72 hours prior to your appointment date, except for emergencies.
- Cash payments, deductibles and co-payments must be paid at the time of service. Payments for medical services not covered by insurance plans are the patient's responsibility.
- It is the patient's responsibility to ensure we have a current and valid referral on file. Otherwise, you will be financially responsible for the visit charges in full.

Please bring attached forms, your photo ID, and insurance cards to your visit.
Please bring a typed or written medication list, your photo ID, and insurance cards to EVERY visit.
Please be aware that if you arrive late for your appointment, you will be asked to reschedule.

Coastal Rheumatology Associates.

PATIENT INFORMATION Referred By:

Name:____Soc Sec #:____________________

First Mid Last

Address:____

Street / PO Box City State Zip

Telephone: Mobile (_____) ____________________ Work (______)_____________Home(______)_________________

Sex at birth: M F Date of Birth: ______/_______/________ E-Mail: ____

Email is required for our Patient Portal and other educational communication

Primary Care Physician: ____

Name Phone Address

Marital Status: __________ Race:_______________________ Ethnicity: Hispanic_______ Non-Hispanic________

Emergency Contact:____

Spouse Info (*If Applicable*):____

EMPLOYMENT INFORMATION

Employed By____Occupation____________________________

Business Address____Business Telephone___________________

Employment Status: FT_____ PT_____ Disabled____ Retired____ Military____ Not Employed______ Student_____

PRIMARY INSURANCE ____Medicare ____Medicaid ____Self Pay _____Commercial

Insurance Company:____

Name HMO / PPO / OPEN ACCESS

Policy #________________________________Group #____________________________Specialist Co-Pay__________

Address_____________________________________City ____________________State_________Zip____________

Name of Insured____ Insured SS #____________________________

Relationship to Patient_________________________________ Date of Birth of Insured______________________

Patient Preference: ____

Hospital Laboratory Pharmacy/Address

SECONDARY INSURANCE ____Not Applicable ____Medicare ____Medicaid _____Commercial

Insurance Company:____

Name HMO / PPO / OPEN ACCESS

Policy #________________________________Group #____________________________Specialist Co-Pay__________

Address_____________________________________City ____________________State_________Zip____________

Name of Insured____ Insured SS #____________________________

Relationship to Patient_________________________________ Date of Birth of Insured______________________

Authorization to Treat and Release Information to Insurance Carrier for Direct Payment to Provider

I hereby authorize medical treatment and the release of any medical information obtained during my care for the purpose of processing insurance claims. I authorize direct payment of benefits from my insurance carrier to my healthcare provider. I understand that if I choose to file my own insurance claims, full payment will be required at the time of service. I acknowledge that I am financially responsible for all charges incurred for services rendered. In the event that legal action becomes necessary to collect any unpaid balance, I agree to be responsible for all associated costs, including handling fees, service charges, court costs, and collection fees, which may include an additional charge of up to 25% of the outstanding balance. To avoid such fees, I agree to make timely payment upon the completion of services. I also authorize the release of medical records to **Coastal Rheumatology** as necessary to ensure continuity of care. I understand that I may request a copy of the practice's HIPAA Notice of Privacy, which is also clearly posted in the lobby.

____ ___________________________ ________________

PATIENT'S SIGNATURE PRINT NAME DATE

____ ___________________________ ________________

GUARANTOR'S SIGNATURE (If other than patient) PRINT NAME DATE

Coastal Rheumatology Associates

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NOTICE OF PRIVACY PRACTICES

Coastal Rheumatology Associates

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

Introduction

At Coastal Rheumatology Associates, we are committed to responsibly using and protecting your personal health information. This Notice of Privacy Practices outlines how we collect, use, and disclose your health information, and your rights regarding that information.

This notice applies to all protected health information (PHI) as defined by federal regulations (HIPAA) at all of our practice locations in Savannah GA, Statesboro GA, and Bluffton SC.

Understanding Your Health Record and Information

I, ____, understand that Coastal Rheumatology Associates creates and maintains paper and/or electronic records of my medical history, symptoms, examinations, test results, diagnoses, treatment, and future care plans. This information serves multiple purposes, including:

- Planning and managing your care and treatment
- Communication among healthcare professionals
- Legal documentation of the care provided
- Verification of services by payers (including insurance)
- Medical education and research
- Public health reporting and planning
- Operational and quality improvement purposes

Understanding how your record is used helps you ensure accuracy, know who has access to your information, and make informed decisions regarding disclosures.

Your Health Information Rights

Although your health record is the physical property of Coastal Rheumatology Associates, the information belongs to you. You have the right to:

- Request a paper copy of this Notice at any time
- Inspect and obtain a copy of your medical record
- Request amendments to your record
- Receive an accounting of certain disclosures (within 30 days of request)
- Request restrictions on the use or disclosure of your information
- Revoke authorization to disclose your information (in writing)
- Request we not submit your PHI to your insurer if services are paid in full by you
- Designate someone to act on your behalf
- File a complaint if you believe your privacy rights have been violated

Our Responsibilities

Coastal Rheumatology Associates is legally required to:

- Protect the privacy and security of your health information
- Provide you with this Notice of Privacy Practices
- Follow the terms outlined in this notice
- Inform you if we cannot comply with a requested restriction
- Notify you of a breach involving your health information
- Communicate with you by alternate means or locations, if reasonably requested

We will not use or disclose your information without your written authorization, except as outlined in this notice.

For More Information or to Report a Problem

If you have questions or believe your privacy rights have been violated, contact:

Privacy Officer

Coastal Rheumatology Associates

Phone: (912) 349-4227

Email: casbury@southeasternra.com

Address: 5400 Waters Avenue, Savannah, GA 31404

You may also file a complaint with:

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue, S.W., Room 509F HHH Building

Washington, D.C. 20201

Phone: 1-877-696-6775

Website: www.hhs.gov/ocr/privacy/hipaa/complaints

There is no retaliation for filing a complaint.

Examples of Permitted Disclosures

Treatment — Information may be shared with your care team (physicians, nurses, specialists) to coordinate your treatment. For example, your physician may share information with a referred specialist to ensure continuity of care.

Payment — Your PHI may be shared with your insurance carrier or other payer to obtain reimbursement. This may include your diagnosis, treatment, and related information.

Healthcare Operations — We may use information to evaluate treatment outcomes, review staff performance, and improve quality of care.

Other Permitted Uses and Disclosures

- Directory Information (if you do not object): name, location, condition, and religious affiliation
- Family Notifications: to notify family or caregivers about your status and location
- Family Communication: when relevant to the individual's involvement in your care
- Research: with IRB approval and privacy safeguards
- Funeral Directors: to carry out legal duties
- Organ Procurement Organizations
- Appointment Reminders and Health Benefits Information
- FDA: for reporting adverse events, product recalls
- Workers' Compensation: as authorized by law
- Public Health and Legal Requirements
- Law Enforcement: in compliance with subpoenas or laws

- Business Associates: for services such as billing, transcription, or consulting (under contract with strict privacy requirements)
- Inmates: if necessary for care, safety, or security
- Oversight Agencies: in good faith reporting of unsafe practices or law violations

Uses and Disclosures Requiring Your Written Authorization

Most other uses and disclosures not described above — particularly those involving psychotherapy notes, marketing, and sale of PHI — require your written authorization. You may revoke authorization in writing at any time.

Health Information Exchange (HIE)

I understand that Coastal Rheumatology Associates may share my medical information with my other healthcare providers via a Health Information Exchange (HIE), in compliance with HIPAA and applicable state laws (Georgia and South Carolina). I acknowledge and consent to this data sharing for treatment, payment, or healthcare operations, including by fax.

State Law

Where Georgia or South Carolina state privacy laws provide greater protection than HIPAA, the practice will comply with the more stringent requirement.

Changes to This Notice

We reserve the right to change the terms of this notice at any time. Changes will apply to all health information we maintain. An updated notice will be available upon request, in our office, and on our website at www.coastalrheumatology.com.

Patient Acknowledgment:

I have read and understand the Notice of Privacy Practices. I consent to the use and disclosure of my protected health information as outlined above.

Patient Name (Printed): ____

Signature: ____

Date: ______________________________

Coastal Rheumatology Associates

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices of Coastal Rheumatology Associates, LLC. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information (PHI) that may be made by the practice, my individual rights regarding my PHI, and the practice's legal duties with respect to my PHI. I understand that I may request a copy of the current Notice of Privacy Practices at any time by contacting the Privacy Officer or any front desk staff member.

I understand that Coastal Rheumatology Associates, LLC reserves the right to change its privacy practices and the terms of its Notice of Privacy Practices at any time. Any revised Notice will be made available to me upon request and posted on the practice's website at www.coastalrheumatology.com.

Patient Name (Printed): ____

Patient Signature: ____

Date: ______________________________

If signing on behalf of the patient:

Representative Name (Printed): ____

Representative Signature: ____

Relationship to Patient: ____

FOR OFFICE USE ONLY — Complete if Acknowledgment Cannot Be Obtained

If the practice is unable to obtain the patient's written acknowledgment, document the reason below.

☐ Patient refused to sign

☐ Patient was unable to sign due to a medical emergency

☐ Communication barrier (describe):

____

☐ Other (describe): ____

Staff Member Name: ____

Staff Member Signature: ____

Date: _____________________________

This form is maintained in accordance with 45 CFR §164.520 of the HIPAA Privacy Rule. Records are retained for a minimum of six (6) years. Privacy Officer: Christina Asbury, casbury@southeasternra.com, (912) 349-4227.

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NOTICE OF NONDISCRIMINATION

Coastal Rheumatology Associates, LLC complies with applicable federal and state civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, gender identity, and sex characteristics), religion, or any other basis prohibited by law.

Coastal Rheumatology Associates, LLC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats), and other auxiliary aids.
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact our Section 1557/ADA/Section 504 Coordinator:

Christina Asbury
Phone: (912) 349-4227
Email: casbury@southeasternra.com
Address: 5400 Waters Avenue, Savannah, GA 31404

If you believe that Coastal Rheumatology Associates, LLC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Coordinator using the contact information above. You can file a grievance in person, by mail, or by email. If you need help filing a grievance, the Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
By mail: 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019 | TDD: 1-800-537-7697

Multi-Language Taglines

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (912) 349-4227.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (912) 349-4227.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (912) 349-4227 번으로 전화해 주십시오.

Chinese (Traditional): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (912) 349-4227。

Chinese (Simplified): 注意：如果您使用简体中文，您可以免费获得语言援助服务。请致电 (912) 349-4227。

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (912) 349-4227.

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (912) 349-4227.

Portuguese: ATENÇÃO: Se você fala português, serviços de assistência linguística, gratuitos, estão disponíveis para você. Ligue para (912) 349-4227.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم (912)-349-4227.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (912) 349-4227 पर कॉल करें।

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. (912) 349-4227 પર કોલ કરો.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (912) 349-4227.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (912) 349-4227.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। (912) 349-4227 मा फोन गर्नुहोस्।

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(912) 349-4227 までお電話ください。

I acknowledge that I have received and reviewed the Notice of Nondiscrimination.

Patient Name (Printed): ____

Patient Signature: ____

Date: ______________________________

Coastal Rheumatology Associates

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YOUR RIGHTS UNDER THE NO SURPRISES ACT

Good Faith Estimate Notice

You have the right to receive a Good Faith Estimate explaining how much your medical care will cost.

Under the No Surprises Act (effective January 1, 2022), healthcare providers must give patients who do not have insurance, or who are not using insurance, an estimate of the expected charges for medical services, including related costs like medical tests, prescription drugs, equipment, and hospital fees.

Your Rights:

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services.
- The practice will provide a Good Faith Estimate in writing at least 1 business day before a scheduled service (for appointments made at least 3 business days in advance) or within 3 business days of scheduling (for appointments made at least 10 business days in advance).
- You may request a Good Faith Estimate before scheduling a service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- You must start the dispute process within 120 calendar days of the date on the bill.
- There is a $25 fee to use the dispute process.

Balance Billing Protections:

- When you receive emergency care, you are protected from surprise billing (also known as balance billing).

- You are also protected from balance billing when you are treated by an out-of-network provider at an in-network facility.
- You cannot be charged more than your in-network cost-sharing amount for these protected services.

For Questions or Complaints:

Contact the practice: Christina Asbury, (912) 349-4227, casbury@southeasternra.com
Federal: CMS at 1-800-985-3059 or visit www.cms.gov/nosurprises
Georgia: Georgia Office of Insurance and Safety Fire Commissioner
South Carolina: South Carolina Department of Insurance

For more information about your right to a Good Faith Estimate, visit **www.cms.gov/nosurprises**

Patient Acknowledgment:

I acknowledge that I have received and reviewed this notice regarding my rights under the No Surprises Act and my right to a Good Faith Estimate.

Patient Name (Printed): ____
Patient Signature: ____
Date: ______________________________

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Medical Provider Services Policy

Coastal Rheumatology Associates

At Coastal Rheumatology Associates, medical services are provided by a team that includes Physicians, Physician Assistants (PAs), and Nurse Practitioners (NPs), collectively referred to as Advanced Practice Providers (APPs).

As a patient of our practice, you may receive care from any of these qualified healthcare providers. While we make every effort to schedule you with your preferred physician, it may not always be possible due to availability. In such cases, you may be scheduled with one of our APPs.

All of our APPs work closely with our physicians, share access to your full medical record, and are committed to providing the same high standard of care. This team-based approach enhances your access to care and supports a more efficient, responsive healthcare experience.

Acknowledgment

By signing below, you acknowledge and accept this policy and understand that you may receive care from a Physician, Physician Assistant, or Nurse Practitioner during your treatment at Coastal Rheumatology Associates.

Patient Name (Printed): ____

Signature: ____

Date: ____________________________

Coastal Rheumatology Associates

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Savannah | Bluffton | Statesboro

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(This advises us of who we are allowed to discuss your medical treatment with)

Patient's Name: ____ Date of Birth: _________________

I authorize Coastal Rheumatology Associates to disclose the following Protected Health Information (PHI) to the individual(s) listed below who are involved in my care or payment for my care:

Name	Relationship	Phone Number
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________

This authorization applies to:

(Please check only one option below)

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or date(s):

____

☐ Other (Please specify):

____

Authorization Statement

I understand that PHI disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal or state privacy laws.

I understand that:

- I may revoke this authorization at any time, in writing, by submitting the revocation to the Coastal Rheumatology Associates office where I received care.

- Any disclosures made prior to receipt of a written revocation will not be affected.
- Coastal Rheumatology Associates cannot require me to sign this authorization as a condition for treatment, unless the purpose of my treatment is to create information for disclosure to a third party.
- I am entitled to receive a copy of this authorization.

Signature/Date: ____

(Date authorization is signed - MM/DD/YYYY)

Printed Name (Patient or Legal Guardian/Personal Representative):

____

Signature (Patient or Legal Guardian/Personal Representative):

____

Relationship to Patient (Required): ____

Expiration of Authorization:

This authorization remains valid until written notice is received to revoke it.

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MEDICAL RECORDS RELEASE AUTHORIZATION

(This form allows your medical records to be sent to another person or facility)

Patient Information (Please print clearly)

Full Name: ____ Date of Birth: ______ / ______ / ________

Address:

____

Street Address / Apt / P.O. Box

City: __________________________ State: _________ Zip Code: _______________

Primary Contact Number: ____

Release To:

I authorize Coastal Rheumatology Associates to release my medical records to:

☐ **Facility:**

Name: ____

Address: ____

City: __________________________ State: _________ Zip Code: _______________

☐ I would like to pick up my records in person

☐ I authorize the following individual to pick up my records on my behalf:

Authorized Person's Name: ____

Information to be Disclosed:

☐ All Billing Records ☐ Complete Medical Record ☐ Partial Medical Record (please specify):

____

Information Date(s):

☐ Office Notes ___________ ☐ Lab Results ___________ ☐ X-Rays __________ ☐ Other __________

Purpose of Disclosure:

☐ Personal Records ☐ Disability ☐ Attorney ☐ Other: ________________________________

Fee Notice:

I understand that a fee may be charged in accordance with state and federal law:

- $0.65 per page for the first 30 pages
- $0.50 per page thereafter

Patient Signature: ____ Date: ______ / ______ / ________

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MEDICAL RECORDS REQUEST AUTHORIZATION

(This form allows Coastal Rheumatology to request your records from another provider)

Patient Information (Please print clearly)

Full Name: ____ Date of Birth: ______ / ______ / ______

Address:

____

Street Address / Apt / P.O. Box

City: _________________________ State: _________ Zip Code: ______________

Primary Contact Number: ____

Request Records From:

☐ **Facility:**

Name: ____

Address: ____

City: _________________________ State: _________ Zip Code: ______________

Information to be Requested (Check all that apply):

☐ Referral ☐ Clinical Notes ☐ Recent Labs and Imaging Reports

☐ Demographics ☐ All of the Above ☐ Other: ____________________________

Please fax all records to our Medical Records Department at (912) 349-4457.

Right to Revoke Authorization:

I understand that I may revoke this authorization at any time in writing. The revocation will not apply to any information already disclosed under this authorization.

Refusal to Authorize Disclosure:

I understand that authorizing this disclosure is voluntary and not a condition of receiving treatment.

Release and Waiver:

If the information requested includes privileged data (e.g., psychiatric, psychological, drug/alcohol abuse, HIV/AIDS, or communicable diseases), I waive any privilege for the purpose of releasing this data. I release Coastal Rheumatology Associates from all legal liability resulting from the release of this information.

Patient Signature: ____ Date: ______ / ______ / ________

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HEALTH HISTORY QUESTIONNAIRE

DATE: ______________ NAME: ___________________________________ DATE OF BIRTH: ____________

Which physician referred you to our clinic?

____

What is the main reason for the referral to our office?

____

When did your symptoms begin?

____

Which local pharmacy do you use?

____

Which mail order pharmacy do you use?

____

Rheumatologic History: (Current or Prior diagnosis)

Rheumatoid Arthritis	**☐ Yes ☐ No**	**Osteoporosis or Osteopenia**	**☐ Yes ☐ No**
Osteoarthritis	☐ Yes ☐ No	Sjogren's syndrome	☐ Yes ☐ No
Psoriasis or Psoriatic Arthritis	☐ Yes ☐ No	Sarcoidosis	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Vasculitis	☐ Yes ☐ No
Lupus	☐ Yes ☐ No	Scleroderma	☐ Yes ☐ No
Fibromyalgia	☐ Yes ☐ No	List Any other Rheumatologic Diagnosis: ____________________________	
Ankylosing Spondylitis	☐ Yes ☐ No		
Mixed Connective Tissue Disease	☐ Yes ☐ No		
Antiphospholipid Syndrome (APS)	☐ Yes ☐ No		
Dermatomyositis or Polymyositis	☐ Yes ☐ No		

Other Medical History:

Cancer (Type and Year)	**☐ Yes ☐ No**	**Eye Problems (Type)**	**☐ Yes ☐ No**
Anxiety or Depression	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
ADHD or Bi-Polar disorder	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Asthma or COPD	☐ Yes ☐ No	Lung Disease / Interstitial	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Crohn's / Ulcerative Colitis	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Back Pain or Neck Pain	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Diverticulitis (Hospitalized?)	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No
Epilepsy / Seizure Disorder	☐ Yes ☐ No	Hepatitis B	☐ Yes ☐ No
GERD (or heartburn)	☐ Yes ☐ No	Hepatitis C	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No
Heart Arrhythmia or A-Fib	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Hypertension	☐ Yes ☐ No	Other Diagnosis: ____________________________	
High Cholesterol	☐ Yes ☐ No		
Skin Disease (Type)	☐ Yes ☐ No		

Are you currently on blood thinning medication? ☐Yes ☐No

If so, What Medication and Why?

____

Coastal Rheumatology Associates

A member of Southeastern Rheumatology Alliance, LLC

DATE: ______________ NAME: _________________________________ DATE OF BIRTH: _____________

Please list all physicians that are currently involved in your care:

Physician Name	Practice/Office Name	Type of Physician/Specialty

Past Surgical History:

Procedure / Surgery	Performing Physician or Practice	Date

Medication Allergies:

Medication Name	Type of Reaction

Social history:

Do you currently or have you ever smoked? __________

If so, how much? ____________________________

If you have quit smoking, how long did you smoke and when did you quit?

____

Do you currently or have you ever used a Vape device? __________

If so, how often? ____________________

Do you currently consume alcohol? __________

If so, what type, how much, and how often?

____

Do you currently or have you ever used any recreational drugs? _____________

If so, what type, how much, and how often?

____

What is your current occupation?

____

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DATE: ______________ NAME: ______________________________ DATE OF BIRTH: ________________

Family History: Have any of your close family members been diagnosed with the following?

Disease	Yes/No	Relationship to you
Rheumatoid Arthritis	☐Yes ☐No	________________________
Osteoarthritis	☐Yes ☐No	________________________
Psoriatic Arthritis	☐Yes ☐No	________________________
Osteoporosis	☐Yes ☐No	________________________
Lupus	☐Yes ☐No	________________________
Gout	☐Yes ☐No	________________________
Vasculitis	☐Yes ☐No	________________________
Heart Disease	☐Yes ☐No	________________________
Hypertension	☐Yes ☐No	________________________
Diabetes	☐Yes ☐No	________________________
Cancer (what type?)	☐Yes ☐No	________________________
Other:		________________________

Current prescription medications:

**Patient may skip this form and bring an accurate medication list.*

Medication Name	Dose / Strength	How often per day	Prescribing MD

Medication Name	Dose / Strength	How often per day	Prescribing MD

Current over the counter medications and Vitamins.

Medication Name	Dose / Strength	How often per day	Physician recommended?

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Rheumatology Medication History

Have you tried ANY of the following medications?

Medication Name	Did it help?	Describe any side effects or problem with the medication.
Actemra	☐Yes ☐No	
Azathioprine (Imuran)	☐Yes ☐No	
Cimzia	☐Yes ☐No	
Enbrel	☐Yes ☐No	
Humira	☐Yes ☐No	
Ibuprofen or other NSAID (ex: Naproxen, Mobic, Celebrex, Aleve)	☐Yes ☐No	
Kevzara	☐Yes ☐No	
Leflunomide (Arava)	☐Yes ☐No	
Methotrexate	☐Yes ☐No	
Orencia	☐Yes ☐No	
Otezla	☐Yes ☐No	
Plaquenil (hydroxychloroquine)	☐Yes ☐No	
Remicade	☐Yes ☐No	
Rinvoq	☐Yes ☐No	
Rituxan	☐Yes ☐No	
Skyrizi	☐Yes ☐No	
Simponi	☐Yes ☐No	
Simponi Aria	☐Yes ☐No	
Sulfasalazine	☐Yes ☐No	
Stelara	☐Yes ☐No	
Tremfya	☐Yes ☐No	

Medication Name	Did it help?	Describe any side effects or problem with the medication.
Xeljanz	☐Yes ☐No	
Other medication:		