Max I. Hamburger, MD, FACP
Paul E. Schulman, MD
Sara J. Johnson, MD

Peter M Rumore, MD FACP
Howard Blumstein, MD
Hong Xu, MD
L.Manuela Marinescu, MD

Lucas M McCaffrey, DO
Mark A. Goldstein, MD
Maryann J. Lee, MD

Rheumatology Associates of Long Island, LLP

Practice Limited to
Arthritis and Rheumatology
Diplomates American Board of Internal Medicine
Sub Specialty Rheumatology

7 Medical Drive
Port Jefferson Sta, NY 11776
Phone: 631 928-4885
Fax 631 928-2944

315 Middle Country Road
Smithtown, NY 11787
Phone: 631 360-7778
Fax: 631 979-1609

1895 Walt Whitman Road
Melville, NY 11747
Phone 631 249-9525
Fax: 631 420-1526

554 East Main Street
Riverhead, NY 11901
Phone: 631 656- 7171
Fax: 631 779-3597

1200 South Avenue
Staten Island, NY 10314
Phone: 718 224-1680
Fax: 718 224-1680

TO: OUR PATIENTS

REGARDING: CHECK-IN AND CHECK-OUT PROCEDURES
CO-PAYMENT

RALI has procedures for check-in, check-out, return visit scheduling, and co-payment collection. At the check-in desk, the staff member will present you with a copy of your:

1) **Patient Information Sheet. You will be asked to review the information and to be certain that it is correct. If the information needs to be updated, please inform the staff at that time. If there is no need to make corrections you will be asked to sign off on the sheet we will do this at every visit. We recognize that this may seem repetitious to those of you whose information remains unchanged. Our staff handles approximately 100 pieces of return mail a week from patients whose information has changed. Thus, we are taking these steps to ensure our ability to communicate with you, and on your behalf when necessary.**

2) **At the check-in desk, you will also be reminded that a co-payment is due at the time of your visit, and the co-payment will be collected at the check-out. Collection of co-payments be the office is required by both insurers and by Medicare. RALI does not make Medicare or insurance company law, or insurance company policy. The check-in and check-out staff is not empowered to make exceptions to co-payment collection policy. When your insurance plan requires a referral for you to see one of the doctors, we must have that referral or we may be forced to re-schedule your visit.**

3) **You must visit the check-out desk before leaving the office. The check-out desk will schedule your return visit. The scheduling of return visits is to be done at the time of check-put. We ask for your cooperation in the regard.**

PATIENT INFORMATION

DATE_____

NAME_____
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS_____CITY_____ ZIP_____

EMAIL ADDRESS_____

HOME PHONE_____CELL PHONE_____

MARTIAL STATUS S_____M_____W_____D_____ BIRTHDATE_____ AGE_____

Due to recent legislation changes, the government is requiring medical facilities to collect the following information.
Please circle all that applies

Ethnicity/Race	Ethnic Group
Black or African American	Not Hispanic or Latino
Hispanic/Latino	
White/Caucasian	

RFERRING DOCTOR_____TEL#_____NPI#_____

EMPLOYER NAME_____OCCUPATION_____PHONE#_____

WORK ADDRESS_____CITY_____ZIP_____

NAME OF SPOUSE_____
(LAST) (FIRST) (MIDDLE INITIAL)

SOUPSE'S EMPLOYER_____OCCUPATION_____PHONE#_____

WORK ADDRESS_____CITY_____ZIP_____

IN CASE OF AN EMERGENCEY NOTIFY/RELATIONSHIP_____PHONE#_____

RETAIL PHARMACY_____PHONE #_____

MAIL ORDER PHARMACY _____PHONE #_____

PRIMARY INSURED_____ INSURANCE COMPANY_____

ID #_____ GROUP #_____

SECONDARY INSURED_____INSURANCE COMPANY_____

ID#_____GROUP#_____

ASSIGNMENT OF BENEFITS	RELEASE OF INFORMATION
I authorize payment of medical benefits to myself Or the named provider for professional services rendered	I authorize the release of any medical information Necessary to process this claim
SIGNED_____DATE_____ (Subscriber)	SIGNED_____DATE_____ (Subscriber)

I have reviewed the above information and there are no changes at this time.

Initials Date Initials Date Initials Date Initials Date Initials Date Initials Date Initials Date

_____ ____ _____ _____ _____ ____ _____ ____ _____ ____ _____ ____ _____ _____

Patient Name_____ Date_____

Please fill in names of all doctors next to their Specialty

Allergist

Cardiologist

Chiropractor

Dermatologist

Endocrinologist

ENT

Gastroenterologist

Nephrologist

Neurologist

OB/GYN

Oncologist/Hematologist

Ophthalmologist

Orthopedist

Pain Management

Family Doctor/PCP/Internist

Psychiatrist

Psychologist

Pulmonologist

Urologist

Vascular

Today's Date_____

Office use only: Physician Reviewed: ☐

Revised 9.22.16

Health History Questionnaire

All Questions contained in this questionnaire are strictly confidential and will become part of your medical record

Last Name: _____ First Name: _____
DOB: _____

F ☐
M ☐

Allergies

Check here if none ☐

(Medication or Other)

Please list any allergy	Reaction you had

Medications

(List your prescribed drugs and over the counter drugs, such as vitamins)

Name of drug	Strength	Frequency	Start date (if known)

Past Medications

Please review this list of arthritis medications. Check circle any that you have taken in the PAST

Anti-Inflammatories (NSAIDs) & Steriods
- Arthrotec
- Celebrex
- Clinoril/Sulinda
- Daypro/Oxaprozin
- Dolobid Diflunisal
- Feldene/Piroxicam
- Indocin
- Lodine/Etodolac
- Motrin/Ibuprofen/Aleve
- Naprosyn
- Ketoprofen
- Voltaren/Diclofenac
- Other:

Rheumatic Biologics
- Actemra
- Cimzia
- Enbrel
- Humira
- Orencia
- Remicade
- Rituxan
- Simponi Aria
- Benlysta
- Stelara
- Cosentyx
- Other:

Pain Relievers/Narcotics
- Hydrocodone
- Oxycodone
- Codeine
- Fentanyl
- Dilaudid
- Methamphetamine
- Methadone
- Demerol
- Dexedrine
- Other:

Fibromyalgia Medication
- Lyrica
- Cymbalta
- Savella
- Gabapentine/Neurotin
- Tramadol/Ultram/Ultracet
- Cyclobenzaprine
- Nortriptyline
- Amitriptyline/Elavil
- Other:

Disease Modifying Anti-Rheumatic Drugs (DMARDS)
- Arava (leflunomide)
- Cytoxan (Cyclophosphamide)
- Xeljanz/Tofacitinib
- Otezla
- Imuran(Azathioorine)
- Methotrexate (Rheumatrex)
- Neoral (Cyclosporine)
- Plaquenil (Hydroxychloriquine)
- Prednisone/ Cortisone
- Sulfasalazine (Azulfidine)
- Other:

Osteoporosis
- Fosamax/Alendronate
- Actonel/Risedronate
- Boniva/Ibandronic acid
- Zoledronic acid/Reclast
- Prolia
- Atelvia
- Estrogen
- Evista/Raloxfiene
- Forteo
- Other:

Gout Medication
- Clochicine
- Uloric
- Krystexxa
- Probenecid
- Lopurin/ Allopurinol
- Other:

Knee Injections
- Orthovisc
- Synvisc
- Euflexxa
- Hyalgan
- Supartz
- Other:

Please list any other past medications your doctor should aware of:

_____

_____

Last Name:_____ **First Name**_____

Personal Health History

Circle any health problems that other doctors have diagnosed you with

Arthritis	**GERD**
Asthma	**Heart problems _____(type)**
Cancer_____(type)	**Hepatitis A,B, or C**
Cataract	**High blood pressure**
Blood Clot	**Kidney Problems**
Colitis	**Osteoarthritis**
COPD	**Pneumonia**
Depression	**Seizures**
Diabetes I or II	**Stroke**
High Cholesterol	**Depression**
Emphysema	**Thyroid problems: Hypo/Hyper**
Fibromyalgia	**Bone Fracture**
Anxiety	**TB/Positive PPD**

Surgical History

Date	**Procedure**

Last Name: _____First Name: _____

Family Health History

Family Member	Age if Alive	Age at Death	Significant Health Problems/Cause of Death
Father			
Mother			
Sibling (Male/Female)			
Sibling (Male/Female)			
Sibling (Male/Female)			
Sibling (Male/Female)			
Sibling (Male/Female)			

Child (Male/Female)	D.O.B	Age at Death	Significant Health Problems/Cause of Death

Last Name:_____ First Name:_____

Social History

Marital Status:

Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Exercise:

None

Type:_____

Frequency:_____ per week

Caffeine:

None ☐ Coffee ☐ Tea ☐ Cola ☐

# of Cups per Day

Tobacco:

Yes ☐ No ☐

Cigarettes ☐ Cigars ☐

# of years_____ or Year that you Quit_____

Alcohol:

Yes ☐ No ☐

How many drinks per week?_____

Recreational drugs: *(non-medical)*

Yes ☐ No ☐

If yes please list:_____

Last Name: _____ First Name: _____

RHEUMATOLOGY ASSOCIATES OF LONG ISLAND

7 Medical Drive	315 Middle Country Rd	1895 Walt Whitman Rd	554 East Main St	1200 South Avenue
Port Jefferson Sta.,NY 11776	Smithtown, NY 11787	Melville, NY11747	Riverhead, NY 11901	Staten Island, NY 1110314
Phone: (631) 928-4885	Phone: (631) 360-7778	Phone: (631) 249-9525	Phone: (631) 656-7171	Phone: (718) 698-3777
Fax: (631) 928-2944	Fax: (631) 979-1609	Fax: (631) 979-1609	Fax: (631) 9791609	Fax: (718) 698- 8777

Name_____ Account_____

Notification Policy

It is our policy not to release confidential and/or unauthorized information by home telephone, answering Machine, work telephone, voice mail, cell phone/ or pager. When returning calls and an answering machine picks up; we do not leave a message unless it is an appointment reminder. Information also will not be left with an unauthorized person who may answer the phone.

If you would like to have information released to someone other than yourself, please complete the following:

I authorize the staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

___yes ___no Home telephone_____

___yes ___no Home Answering Machine_____

___yes ___no Fax Home_____

___ yes ___no Fax Work_____

___yes ___no Work phone/Voicemail_____

___yes ___no Cell phone/Voicemail_____

___yes ___no E-mail_____

___yes ___no Pager_____

Please list names of authorized people we may leave messages with (i.e. spouse, boyfriend, girlfriend, parent, grandparent etc.):

Name_____ Relationship_____ yes __ no__
Name_____ Relationship_____ yes __ no__
Name_____Relationship_____ yes __ no__

Who may we discuss your financial situation with?

Name_____Relationship_____ yes__ no__
Name_____Relationship_____ yes__ no__

_____ _____
SIGNATURE (Patient/Guardian) **DATE**