MIDSTATE RHEUMATOLOGY CENTER
NEW PATIENT REGISTRATION FORM

Patient Information

Last Name: First Name: Date of Birth: Age:

Sex Assigned at Birth: ☐ M ☐ F Gender Identity: Marital Status:

Street Address:

City: State: Zip Code:

Home Phone: Cell Phone:

Email Address:

How did you hear about us? ☐ PCP ☐ Specialist ☐ Family/Friend
☐ Google Search ☐ Insurance Website ☐ Social Media ☐ Other:

Race (select all that apply):

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ Middle Eastern/North African ☐ White

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Language: Occupation:

Information Sharing & Emergency Contact

With whom may we share your health information?

Relationship: Phone:

Emergency Contact: Relationship: Phone:

Care Team & Pharmacy

Primary Care Physician Name: Phone:

Referring Physician (if applicable): Phone:

Pharmacy Name: Address: Phone:

Insurance Information

Person Responsible for This Account: Date of Birth:

Address (if different): Phone:

Primary Insurance: Member ID: Group No.:

Subscriber's Name: Date of Birth: Relationship to Patient:

Secondary Insurance: Member ID: Group No.:

Consent to Treat

I voluntarily consent to examination, diagnostic testing, and medical treatment by Midstate Rheumatology Center, including but not limited to physical examinations, laboratory testing, imaging, injections, infusions, and other procedures or treatments my provider determines to be medically necessary or advisable.

I understand that no guarantee has been made regarding the outcome of any examination or treatment. I understand that I have the right to ask questions about any recommended treatment and to accept or refuse any specific treatment at any time.

Patient Acknowledgement

I certify that the information provided on this registration form is true, complete, and accurate to the best of my knowledge. I understand that it is my responsibility to notify Midstate Rheumatology Center promptly of any changes to my personal information, contact information, insurance coverage, pharmacy, primary care provider, emergency contact, or any other information contained on this form.

I understand that providing accurate and up-to-date information helps ensure appropriate communication, coordination of care, and timely processing of insurance claims.

By signing below, I also acknowledge and provide the Consent to Treat described above.

Patient/Legal Guardian Signature: _____

Printed Name: _____ Date: _____

MIDSTATE RHEUMATOLOGY CENTER
MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____ Today's Date: _____ Age: _____

Medical History — Please check all conditions you have or have had

☐ Angina (Chest Pain)	☐ Anxiety	☐ Asthma	☐ Bleeding Disorder
☐ Blood Clots	☐ Cancer: _____	☐ Celiac Disease	☐ Congestive Heart Failure
☐ COPD/Emphysema	☐ Crohn's/Ulcerative Colitis	☐ Depression	☐ Diabetes
☐ Diverticulitis	☐ Fibromyalgia	☐ Frequent Urinary Tract Infection	☐ Gout
☐ Heart Attack	☐ Herniated Disc	☐ High Blood Pressure	☐ High Cholesterol
☐ HIV/AIDS	☐ Inflammatory Eye Disease i.e. Uveitis/Scleritis	☐ Kidney Disease	☐ Kidney Stone
☐ Leukemia	☐ Liver Disease	☐ Lupus (Systemic)	☐ Migraines
☐ Osteoarthritis	☐ Osteopenia	☐ Osteoporosis	☐ Psoriasis
☐ Psoriatic Arthritis	☐ Raynaud's Disease	☐ Rheumatoid Arthritis	☐ Seasonal Allergies
☐ Seizures	☐ Spinal Stenosis	☐ Stomach Ulcers	☐ Stroke
☐ Suicide Attempt	☐ Thyroid Disease	☐ Tuberculosis	

Other diagnoses not listed above: _____

Surgical History

Surgery / Procedure: _____ Year: _____
Surgery / Procedure: _____ Year: _____
Surgery / Procedure: _____ Year: _____
Surgery / Procedure: _____ Year: _____
Surgery / Procedure: _____ Year: _____

Allergies (medications, foods, latex, etc.)

☐ No Known Allergies

Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____

Current Medications

Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
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Medication: _____ Dose: _____ Frequency: _____

Social History

Tobacco Use: ☐ Never ☐ Former ☐ Current Packs/Day: Years:

Alcohol Use: ☐ Never ☐ Occasional ☐ Regular Drinks/Week:

Recreational Drug Use: ☐ No ☐ Yes Type:

Occupation: Exercise: ☐ None ☐ Occasional ☐ Regular

Women's Health

☐ Not Applicable

Pregnancies (Gravida): Live Births (Para): Last Menstrual Period:

☐ Currently Pregnant ☐ Post-Menopausal Age at Menopause:

☐ Hormone Replacement Therapy ☐ Birth Control / Hormonal Contraception

Review of Systems — Please check any symptoms you are currently experiencing

☐ Fever	☐ Night Sweats	☐ Joint Stiffness	☐ Joint Pain
☐ Joint Swelling	☐ Back Pain	☐ Neck Pain	☐ Dry Eyes
☐ Dry Mouth	☐ Hearing Loss	☐ Shortness of Breath	☐ Cough
☐ Chest Pain	☐ Blood in Stool	☐ Rash	☐ Tingling or Numbness
☐ Blood in Urine	☐ Swollen Glands	☐ Loss of Appetite	☐ Weight Loss
☐ Sinus Congestion	☐ Signs of Depression	☐ Mouth Sores	☐ Leg Swelling
☐ Fatigue	☐ Muscle Pain / Weakness	☐ Raynaud's Phenomenon (fingers turning white/blue in cold)	☐ Photosensitivity (rash with sun exposure)
☐ Hair Loss	☐ Skin Tightening	☐ Difficulty Swallowing	☐ Eye Redness or Pain

Family History

Relationship: Medical Conditions:

Relationship: Medical Conditions:

Relationship: Medical Conditions:

Relationship: Medical Conditions:

Relationship: Medical Conditions:

Relationship: Medical Conditions:

Relationship: Medical Conditions:

Relationship: Medical Conditions:

Additional Health Screening

Have you fallen in the last year? ☐ Yes ☐ No

Have you ever had a bone density scan? ☐ Yes ☐ No If yes, when?

Do you have an advance directive? ☐ Yes ☐ No