Dear __________________________:

You have an appointment scheduled with Dr. __________________________ on __________________________ at __________________________. Please arrive at __________________________ so we may complete your registration in time for the visit. It is very important that you confirm this appointment two business days before the scheduled appointment by dialing our office at 804-323-1401 option 1. Call on __________________________ by 12:00 noon, failure to do so will result in the cancellation of this appointment. If we are unable to contact you, your appointment will be automatically cancelled and filled with another patient.

We have enclosed paperwork that must be completed ahead of time and brought with you to the appointment along with your insurance cards, a picture identification card or driver’s license, and copay if applicable. The appointment will last at least an hour as the doctor will obtain a medical history and a physical exam.

If your insurance plan changes from when you originally made this appointment, please notify us to make sure we accept the new insurance plan. Please remember that if your insurance requires a referral then it is the patient's responsibility to make sure that we receive the referral by the time of the visit or you may be asked to reschedule. Please note that if you are a Medicare patient, you must fill out the section titled “Lifetime Form” with your name as the beneficiary, with your signature and the date.

We also ask that you have all of your doctors' offices send a copy of all lab, office visit notes, and radiology results from the past year to fax number 804-323-1878 as soon as possible. We do not need any radiology films or discs, just the written report.

Our office is located in the Atrium wing of Johnston Willis Hospital on the first floor in Suite 1200.

If you need to call the office the morning of your appointment due to illness, needing directions or are running late and you are calling before 8:30am, please call 804-323-1401 extension 302.

Arthritis Specialists, Ltd.

You may now go visit our website at: www.arthritisspecialistsltd.com
Directions to Arthritis Specialists, Ltd. Johnston Willis Office

From Goochland and points West:

Travel east on I-64
Take 288 South
Cross the James River and exit onto Midlothian Turnpike East
Travel on Midlothian Turnpike to Johnston Willis Drive
Turn left onto Johnston Willis Drive
Follow the signs to the Atrium which is to the right of the Emergency Room
Our office is located on the 1st floor of the Atrium, Suite 1200 beside the information desk

From the West End: (Follow directions below or use 288 directions above)

Travel South on Parham Road
Cross the Willey Bridge, Parham Road then becomes Chippenham Parkway
Take Huguenot Road exit and turn right
Travel down Huguenot Road to Midlothian Turnpike
Turn left on Midlothian Turnpike
Turn left on Johnston Willis Drive
Follow the signs to the Atrium which is to the right of the Emergency Room
Our office is located on the 1st floor of the Atrium, Suite 1200 beside the information desk

From North side and the Fan:

Travel South on I-95 and follow signs to Powhite Parkway South
Travel across the James River and through the toll plaza
Exit onto Midlothian Turnpike West towards Midlothian
Travel about 3 miles and turn right onto Johnston Willis Drive
Follow the signs to the Atrium which is to the right of the Emergency Room
Our office is located on the 1st floor of the Atrium, Suite 1200 beside the information desk

From the South:

Travel North on I-95
Exit on Chippenham Parkway North
Travel on Chippenham North to Midlothian Turnpike
Exit on Midlothian Turnpike West
Travel about 4 miles and turn right onto Johnston Willis Drive
Follow the signs to the Atrium which is to the right of the Emergency Room
Our office is located on the 1st floor of the Atrium, Suite 1200 beside the information desk
Our office is located in the Atrium wing of the Johnston Willis Hospital on the first floor in Suite 1200.
### Arthritis Specialists, Ltd.

#### Patient Registration

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>FULL NAME</td>
<td>S.S. NUMBER</td>
</tr>
<tr>
<td>ADDRESS</td>
<td>CITY, STATE AND ZIP</td>
</tr>
<tr>
<td>BIRTH DATE</td>
<td>AGE, SEX, MARITAL STATUS</td>
</tr>
<tr>
<td>PRIMARY PHONE</td>
<td>SECONDARY PHONE</td>
</tr>
<tr>
<td>LANGUAGE</td>
<td>RACE, ETHNIC GROUP</td>
</tr>
<tr>
<td>EMPLOYER</td>
<td>OCCUPATION</td>
</tr>
<tr>
<td>ADDRESS</td>
<td>BUSINESS PHONE</td>
</tr>
<tr>
<td>EMERGENCY CONTACT</td>
<td>PHONE</td>
</tr>
<tr>
<td>ADDRESS (IF DIFFERENT FROM ABOVE)</td>
<td>PHONE</td>
</tr>
<tr>
<td>FAMILY PHYSICIAN (IF ANY)</td>
<td>LOCATION, PHONE</td>
</tr>
<tr>
<td>REFERRING PHYSICIAN (IF ANY)</td>
<td>LOCATION, PHONE</td>
</tr>
</tbody>
</table>

#### Insurance Information (Name of Insurance Companies)

<table>
<thead>
<tr>
<th>PRIMARY</th>
<th>SECONDARY</th>
<th>TERTIARY</th>
</tr>
</thead>
</table>

#### Patient Authorization

I hereby authorize the release of medical information to my physician(s) or my insurance company. In order to help us provide you with the best services possible, we have adopted the following billing policy:

I understand that I am responsible for payment of my bill in full, regardless of what my insurance pays.

In the event that the responsible party defaults on payment to this office for professional services rendered within the preceding 60 days, the responsible party agrees to pay to Arthritis Specialists, Ltd. expenses incurred in effecting collection of this account, including attorney's fees equal to 33 1/3% of the balance due, as well as applicable court costs. These sums are expressly recognized to be in addition to the balance on the account at the time it is placed for collection.

Arthritis Specialists, Ltd. requires at least 24 hours notice for all appointment cancellations. If you are unable to provide 24 hours notice, you will be billed a $25.00 charge for your scheduled appointment time.

I request that the physicians and staff of Arthritis Specialists, Ltd. have any and all access to my electronic medical records for the purpose of providing me medical care.

I give my permission for physicians and staff of Arthritis Specialists, Ltd. to leave voice mails on my home phone or work phone.

By supplying my home phone number, mobile phone number, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s) to notify me of pending appointments.

Patient agrees that the physicians of Arthritis Specialists, Ltd. are specialists in Rheumatology and are not in any way practicing as Primary Care Physicians or General Internal Medicine Physicians for the patient. Furthermore, patient represents that he or she has a Primary Care Physician who serves him or her for general medical problems, both routine and emergency in nature.

Your signature below attests to your understanding and willingness to comply with the above policy. Thank you for your cooperation.

In the event one of Arthritis Specialists, Ltd.'s employees is exposed to your blood or body fluids, you consent to have your blood drawn to test for blood borne pathogens.

Signature: _____________________________ Date __________

#### LIFETIME FORM

Beneficiary Name: ___________________________ Health Insurance #: ___________________________  

I request that payment under the Medicare Insurance Program be made either to me or on my behalf to Arthritis Specialists, Ltd. for any services furnished by that physician/provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

Beneficiary Signature: ___________________________ Date __________
Name ___________________________ Date __________ DOB __________

Reason for Visit: ________________________________________________________

Past Medical History

<table>
<thead>
<tr>
<th></th>
<th>Arthritis</th>
<th>Asthma</th>
<th>Chronic Renal Insufficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back Pain</td>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clots in Legs</td>
<td>Clots in Lungs</td>
<td>Congestive Heart Failure</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>Crohn’s Disease</td>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Diabetes (Type I)</td>
<td>Diabetes (Type II)</td>
<td>Fibromyalgia</td>
<td></td>
</tr>
<tr>
<td>Gout</td>
<td>Glaucoma</td>
<td>Heart Attack</td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Heart Disease – Angina</td>
<td>Hepatitis</td>
<td></td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>Hypertension</td>
<td>Intestinal Bleeding</td>
<td></td>
</tr>
<tr>
<td>Kidney Stones</td>
<td>Lupus</td>
<td>Migraine Headache</td>
<td></td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>Osteopenia</td>
<td>Osteoporosis</td>
<td></td>
</tr>
<tr>
<td>Peptic Ulcer Disease</td>
<td>Prostate Trouble</td>
<td>Reflux Heart Burn</td>
<td></td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td>Seizures</td>
<td>Sjogren’s</td>
<td></td>
</tr>
<tr>
<td>Strep Throat (Recent)</td>
<td>Tension Headache</td>
<td>Ulcerative Colitis</td>
<td></td>
</tr>
<tr>
<td>Underactive Thyroid</td>
<td>Urinary Tract Infection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other: (not listed above) __________________________________________________

Surgical History/Operations (Please include date if possible)  

No Known Surgical History

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Current Medications, Dosage and Frequency

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No Known Medication Frequency

Vitamins

Allergies to Medications (Please include reaction if possible)

No Known Drug Allergies

Social History

( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed

Employment – Occupation

Current Smoking Status: ( ) Never Smoked ( ) Smoke Every day ( ) Smoke Some Days

( ) Former Smoker (Packs per day___) How long have/did you smoked? _____ Age Started____

Do you drink caffeinated beverages? ( ) No ( ) Yes Number per day? _____

Do you drink alcohol? ( ) No ( ) Yes Number per week? _____

Have you done any illicit drugs? ( ) No ( ) Yes

Family History (Please include relation if possible)

No Known Family History

<table>
<thead>
<tr>
<th>Ankylosing Spondylitis ( )</th>
<th>Arthritis ( )</th>
<th>Asthma ( )</th>
<th>Cancer ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crohn’s Disease ( )</td>
<td>Diabetes ( )</td>
<td>Epilepsy/Seizure ( )</td>
<td>Gout ( )</td>
</tr>
<tr>
<td>Heart Disease ( )</td>
<td>High Blood Pressure ( )</td>
<td>Kidney Disease ( )</td>
<td>Lupus or SLE ( )</td>
</tr>
<tr>
<td>Mental Illness ( )</td>
<td>Osteoarthritis ( )</td>
<td>Osteoporosis ( )</td>
<td>Psoriasis ( )</td>
</tr>
<tr>
<td>Psoriatic Arthritis ( )</td>
<td>Rheumatoid Arthritis ( )</td>
<td>Stroke ( )</td>
<td>Tuberculosis ( )</td>
</tr>
<tr>
<td>Ulcerative Colitis ( )</td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Review of Systems** (please mark the symptoms that you have on a regular basis)

**Constitutional Symptoms**
- Recent Weight Gain
  - Amount (lbs.)
- Recent Weight Loss
  - Amount (lbs.)
- Fatigue
- Weakness
- Night Sweats
- Fever
- Hours of Sleep Per Night
- Chills

**Musculoskeletal**
- Morning Stiffness
  - How long
- Joint Pain
  - How long
- Joint Swelling
  - How long
- Neck Pain
- Back Pain
- Muscle Pain or Tenderness
- Muscle Nodules
- Deformities of the Joints
- Other

**HEENT**
- Dry Mouth/Dry Eyes
- Blurred Vision
- Loss of Vision
- Mouth Ulcers
- Pain or Redness of the Eyes
- Tender Scalp
- Jaw Pain while Chewing Food

**Hematologic/Lymphatic**
- Swollen Glands
- Clots in Lungs or Legs
- Anemia
- Excess Bleeding

**Skin**
- Rash
- Psoriasis
- Tightening of the Skin
- Nodules
- Sensitivity to Sunlight
- Easy Bruising
- Nail Changes or Pits
- Loss of Hair All Over or Spots
- Facial Rash

**Pulmonary**
- Coughing
- Wheezing
- Sputum Production
- Shortness of Breath
- Chest Pain with Deep Breath
- Coughing Up Blood
Fingers White, Purple, Blue in Cold
Shortness of Breath while Lying Flat
Heart Pounding
Chest pain/Angina
Heart Murmurs
Swollen Legs or Feet
Wake at Night to Sit Up and Catch Breath

Heartburn
Trouble Swallowing
Nausea
Stomach Pain
Diarrhea
Constipation
Blood in Stool
Black/Tarry Stools
Hepatitis
Yellow Skin/Eyes

Wake at Night to Sit Up and Catch Breath
Fainting Spells
Numbness/Tingling Arms/Legs

Heart Pounding
Chest pain/Angina
Heart Murmurs
Swollen Legs or Feet
Wake at Night to Sit Up and Catch Breath

Raynaud’s
Fingers White, Purple, Blue in Cold
Shortness of Breath while Lying Flat
Heart Pounding
Chest pain/Angina
Heart Murmurs
Swollen Legs or Feet
Wake at Night to Sit Up and Catch Breath

Epilepsy/Seizures
Muscle Weakness
Headaches
Dizziness
Fainting
Muscle Spasms
Loss of Coordination
Fainting Spells
Numbness/Tingling Arms/Legs

Anxiety
Depression
Suicidal Thoughts

Burning while Urinating
Urinating Frequently
Kidney Stones
Blood in Urine
Night time Urination
Prostate Troubles
Miscarriages (Number:__)
Flank Pain

Patient Signature:__________________________________________Date:

Physician Signature:________________________________________Date Reviewed:
Dear Patient,

The appointment that you have made with our physician is a one hour consultation that has been set aside for you and you only.

At this time the physician will take an extended history from you and perform an extensive exam and evaluation.

If for some reason you cannot keep this appointment, you must call our office two business days in advance to cancel or reschedule. In not doing so, we will not be able to schedule another appointment for you until we have a $200.00 deposit to hold your appointment. After receiving your deposit, our office will call you and schedule the next available appointment.

We will refund this money back to you if you keep your appointment and gladly file any insurance that is applicable. If you do not keep your second appointment, the deposit is non-refundable.

Sincerely,

The Physicians & Staff of Arthritis Specialists, Ltd.