South Florida Rheumatology

4700 Sheridan St, Suite C, Hollywood, FL 33021
Phone- (954) 961-3252 Fax- (954) 678-3007

1 SW 129th Ave #401 Pembroke Pines, FL 33027
Phone- (954) 450-8980 Fax-(954) 678-3007

1040 Weston Rd. Suite 215 Weston, FL (954) 961-3252

Last Name: _____ First Name: _____

Home Address: _____ APT #_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Mobile: _____

Email Address: _____

Race: **(check box)** ☐ White ☐ Asian ☐ Black/African American ☐ Hawaiian ☐ Pacific Islander

Ethnicity: **(check box)** ☐ Hispanic/Latino ☐ Not Hispanic/Latino Language Spoken: ☐

Date of Birth: _____ Social Security #_____

Marital Status: **(check box)** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sex: **(check box)** ☐ Male ☐ Female

Family Physician (PCP) _____ Phone # _____

Parent or Responsible Party: _____ or ☐ **SELF**

Relationship to Patient: _____ or ☐ **SELF,** Name of Spouse; _____

Employer or Parents Employer: _____ Phone # _____

Occupation: _____, Insurance with Employer: **(check box)** ☐ **YES** ☐ **NO**

Health Plan Name: _____ **(check box)** ☐ **HMO** ☐ **PPO**

Health Plan Member Number: _____ Group #_____

Emergency Contact Information:

Name:_____ Phone#_____

Number of Children:_____**Ages:**_____

Do You Smoke Yes No	**Do you drink alcohol?** Yes No	**Do you use street/recreational drugs?** Yes No
If Yes: How many packs a day? _____ How many years? _____ Quit Date: _____	If Yes: How much? _____ How often? _____ Quit Date: _____ In a recovery program?	If Yes: What? _____ How often? _____ Quit Date: _____ In a recovery program?

Family History

Mother	Father
Living Yes No If No Age @ death _____	Living Yes No If No Age @ death _____
Medical Conditions _____ _____ _____ _____ _____ _____	Medical Conditions _____ _____ _____ _____ _____ _____

Do you have a family history of:

Yes No Osteoporosis If Yes, Who: _____
Yes No Rheumatoid Arthritis If Yes, Who: _____
Yes No Osteoarthritis If Yes, Who: _____
Yes No Gout If Yes, Who: _____
Yes No Other Connective Tissue Disease

If Yes, What: _____ Who: _____

☐ Denies Any Significant PMHx

CIRCULATORY SYSTEM

☐ Abdominal Aortic Aneurysm
☐ Deep Venous Thrombosis
☐ Giant Cell Arteritis
☐ Hyperlipidemia
☐ Hypertension
☐ Myocardial Infarction
☐ Palpitations
☐ Phlebitis
☐ Raynauds' Phenomenon
☐ Vasculitis

Other:

ENDOCRINE & METABOLIC

☐ Diabetes
☐ Obesity, Morbid
☐ Thyroid Disease
☐ Thyroid Nodule

Other:

FEMALE HEALTH HISTORY

☐ Abnormal Mammogram
☐ Abnormal Pap Smear
☐ Amenorrhea
☐ Infertility
☐ Irregular Menstrual Cycle
☐ Miscarriages
☐ PMS

Last Normal Menstrual Period (date):

Other:

GASTROINTESTINAL

☐ GERD
☐ GI Bleeding
☐ Cirrhosis, non-specified
☐ Hemmorrhoids
☐ Hepatitis
☐ Inflammatory Bowel Disease
☐ Irritable Bowel Syndrome
☐ Peptic Ulcer Disease
☐ Rectal Bleeding
☐ Renal Artery Stenosis
☐ Ulcers

Other:

GENITOURINARY

☐ Bladder Outlet Obstruction
☐ BPH
☐ Incontinence
☐ Prostatitis
☐ Pyelonephritis
☐ Stress Incontinence (Female)
☐ Urinary Tract Infection

Other:

HEENT

☐ Hearing Loss, Unspecified
☐ Inflammatory Eye Disease
☐ Oral Ulceration
☐ Sinusitis
☐ Sjogren's Disease/Sicca Syndrome

Other:

HEMATOLOGY

☐ Anemia
☐ Antiphospholipid Syndrome
☐ Bleeding Disorders
☐ Cancer
☐ Sickle Cell Disease
☐ Thrombocytopenia
☐ Vitamin B12 Deficiency

Other:

INFECTIOUS DISEASES/STDs

☐ Chlamydia
☐ Genital Herpes
☐ Genital Warts
☐ Gonorrhea
☐ HPV
☐ Infectious Mononucleosis
☐ Lyme Disease
☐ Parvovirus B19
☐ Syphilis
☐ Tuberculosis

Other:

MUSCULOSKELETAL

☐ Ankylosing Spondylitis
☐ Disc Disease
☐ Fibromyalgia
☐ Gout
☐ Hip Fracture
☐ Lupus
☐ Osteoarthritis
☐ Osteoporosis/Osteopenia
☐ Psoriatic Arthritis
☐ Sciatica
☐ Spinal Stenosis
☐ Tendonitis
☐ Vertebral Compression Fracture
☐ Other Fractures

NEUROLOGIC

☐ CVA Embolic
☐ CVA Hemmorhagic
☐ Headache, Not Specified
☐ Migraine Headache
☐ Peripheral Neuropathy
☐ Post Herpetic Neuralgia
☐ Tension Headache
☐ Tremors

Other:

PSYCHIATRY

☐ Alcoholism
☐ Anxiety Disorder
☐ Depression

Drug Abuse:

☐ Insomnia
☐ Panic Disorder

Other:

PULMONOLOGY

☐ Asthma
☐ Obstructive Sleep Apnea
☐ COPD
☐ Pneumonia
☐ Pulmonary Embolism
☐ Pulmonary Fibrosis
☐ Pulmonary Hypertension

Other:

RENAL

☐ Hematuria
☐ Kidney Stones
☐ Nephritis
☐ Proteinuria
☐ Pyelonephritis
☐ Renal Transplant

Other:

SKIN

☐ Eczema
☐ Psoriasis

Other:

Family Medical History

List all Relevant History, Include Grandparents, Parents, Siblings and Children

1. _____
2. _____
3. _____
4. _____
5. _____

_____ **Adopted, history unknown**
_____ **No relevant Family History**

Social History

Caffeine Consumption (type and amount) _____

Alcohol Consumption (type, amount and frequency) _____

Tobacco Use (type, amount and frequency) _____

Recreational Drug Use _____

Reason for today's visit _____

_____

Medication Allergies _____

_____

_____

Pharmacy_____**Phone #**_____

Medical History

Please list your medical conditions:

_____	_____
_____	_____
_____	_____
_____	_____

Hospitalizations & Surgeries - Please list all

Year	Operation / Illness	Year	Operation / Illness
____	_____	____	_____
____	_____	____	_____
____	_____	____	_____
____	_____	____	_____

Allergies - Please list any allergies to medications, foods, x-ray dyes, environmental items, adhesive tapes. *Example: Penicillin causes rash, eggs cause hives, Pollen causes sneezing*.

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications (list all medications you are now taking or have taken in the last 2 weeks)

Name of Medication	Doses / Times per day	Reason for taking	How long?
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

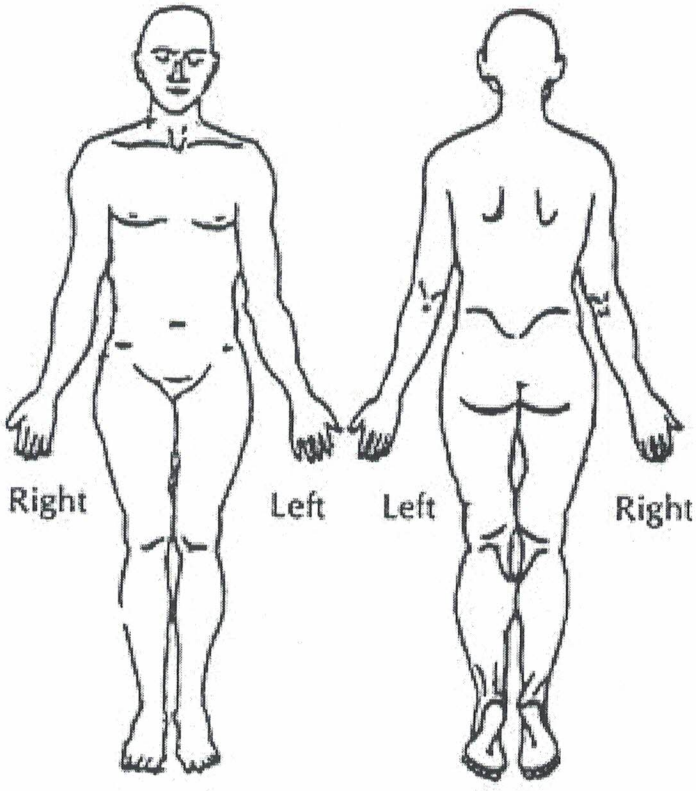
Activity – Please check the most appropriate answer

Vigorous Activity (Running, lifting heavy objects, etc)		❒ Yes Limited a little	❒ No
Moderate Activity (Pushing vacuum cleaner, playing golf, moving a table, etc.)		❒ Yes Limited a little	❒ No
Carrying / lifting groceries		❒ Yes Limited a little	
Climbing stairs		❒ Yes Limited a little	
Bending, kneeling, or stooping		❒ Yes Limited a little	
Bathing or dressing self		❒ Yes Limited a little	
Writing		❒ Yes Limited a little	
Feeding self, cutlery		❒ Yes Limited a little	
Getting out of a chair, car		❒ Yes Limited a little	
Walking one block		❒ Yes Limited a little	❒ No Not limited at all
Walking one mile		❒ Yes Limited a little	❒ No Not limited at all

Where Do You Have Pain?

Please Mark Areas Below

PAIN **(X)** SWELLING **(+)** STIFFNESS **(-)**



Where do you have pain? _____

How often? _____ For how long? _____

What relieves the pain? _____

What causes or increases the pain? _____

Do you have swelling in your joints? _____

Do you have morning stiffness? ❒ Yes ❒ No If Yes, for how long? _____

What time of day is the worst for your symptoms? _____

Signature of Reviewing Physician: _____ Date: _____

KAHN, RISKIN & SANTIAGO, MD's, P.A.

4700 Sheridan St, Suite C, Hollywood, FL 33021
Phone- (954) 961-3252 Fax- (954)964-6168

1 SW 129th Ave #401 Pembroke Pines, FL 33027
Phone- (954) 450-8980 Fax-(954) 441-9033

LIFETIME
AUTHORIZATION FOR INSURANCE PAYMENT

I, _____ authorize any holder of medical or other information about me to release to my Insurance Carrier(s) or to the billing agent, of Drs. Kahn, Riskin and Santiago, any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I have been provided with a notice of Privacy Practices of Charles Kahn, MD, FACP, FACR, Wayne Riskin, MD, FACP, FACR, and Dr. Santiago-Casas, MD, FACP,FACR, that HIPPA outlines what will be done with my Protected Health Information.

_____ _____
Print Patient's Name Patient's Signature

_____ _____
Print Name & Relationship
If patient is unable Signature of Other

_____

Spouse Information (if primary insured)

_____
Name

_____
DOB

_____
Social Security Number

KAHN, RISKIN & SANTIAGO, MD's, P.A.

4700 Sheridan St, Suite C, Hollywood, FL 33021
Phone- (954) 961-3252 Fax- (954)964-6168

1 SW 129th Ave #401 Pembroke Pines, FL 33027
Phone- (954) 450-8980 Fax-(954) 441-9033

NO-SHOW POLICY

Dear Patient:

We understand that there are legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling well in advance if you are unable to keep an appointment. We would like to have an option to offer that appointment to another patient who needs to see the doctor. Please let this notice serve to notify you that if you fail to give us a 24-hour notice of cancellation, there will be a $50.00 cancellation fee billed to your account that cannot be filed to your insurance.

Signature of
Patient:_____Date:_____

Printed Name:_____

KAHN, RISKIN & SANTIAGO, MD'S, P.A.

4700 Sheridan St, Suite C, Hollywood, FL 33021
Phone- (954)961-3252 Fax- (954) 964-6168

1 SW 129th Ave #401 Pembroke Pines, FL 33027
Phone- (954) 450-8980 Fax- (954) 441-9033

Office Hours

Hollywood office: Monday through Friday 9:00am-5:00pm

Pembroke Pines office: Tuesdays & Thursdays 9:00am-5:00pm

Co-Payments

Due at the time services are rendered

Appointments

If for some reason you can't make your scheduled appointment, please give us notice of cancellation at least 24 hours in advance; otherwise, a $50 fee will be applied to your bill. When you arrive, you will be asked to check in and to fill out necessary paperwork.

Changes

If your insurance, address, or phone number has changed, please let us know so we can give you new paperwork to update your records.

Work-ins

If your need for an appointment is urgent and we have to work you in to our busy schedule, please note that there will be a wait time, as scheduled patients must be seen first.

Medications

It is important for you to bring in all current medications for every visit, so we can avoid problematic medicine interactions and dosages.

Refills

If you need a refill on a medication we prescribe, have your pharmacy contact our office on weekdays when your chart is available to our physicians.

Billing Questions

If you have any questions concerning our billing processes and requirements please call Tina at **(954) 961-3252.**

HMO's and Referrals

With HMOs and certain insurance plans, you will need to get a referral from your primary physician before scheduling your visit with our offices. If you need one of our doctors to prepare forms such as insurance forms, personal letters, or specific medical records, certain fees will apply:

Forms and Records

The following fee schedule applies for Doctor preparation of certain forms, personal letters and medical record copies.

1. **1. Insurance Forms- $25/form and up**
2. **2. Personal Letters- $25/each and up**
3. **3. Medical Records- $1/page for the first 25 pages, then .25/each additional page.**

Please Sign x _____