TARRANT ARTHRITIS CENTER

Thank you for choosing Tarrant Arthritis Center for your care and we look forward to your visit. Attached is the new patient paperwork that needs to be completed prior to your appointment.

You also need to bring the following:

- **New Patient Paperwork**
- **Picture ID**
- **Insurance Card(s)**
- **Proper Identification such as a Driver's License.**

If you are unable to complete the paperwork packet, please arrive at least 15 minutes prior to appointment time so that this can be completed.

Thank you in advance!

Tarrant Arthritis Center

Phone: 817-865-3939

Fax: 817-865-3846

TARRANT ARTHRITIS CENTER

PATIENT REGISTRATION

Patient Information: (*Please use legal name, no nickname)*

Last Name: _____ First Name: _____ Middle: _____

Address: _____

City: _____State: _____Zip Code: _____

Cell Phone: _____Home Phone: _____Work Phone: _____

Social Security Number: _____

Date of Birth: _____Age: ____Sex: _____Marital Status: _____

Email Address: _____

Employer Name & Address: _____

_____

Emergency Contact Name: _____Phone number: _____

GUARANTOR INFORMATION: *(If different from patient)*

Last Name: _____First Name: _____Middle Initial: _____

Date of Birth: _____Social Security #: _____Relationship: _____

Employer Name: _____Phone #: _____

If you have a Personal legal Representative /Guardian who has been filling out the paperwork on your behalf, please fill out information below

Legal Representative Name _____

Legal Representative Telephone No_____

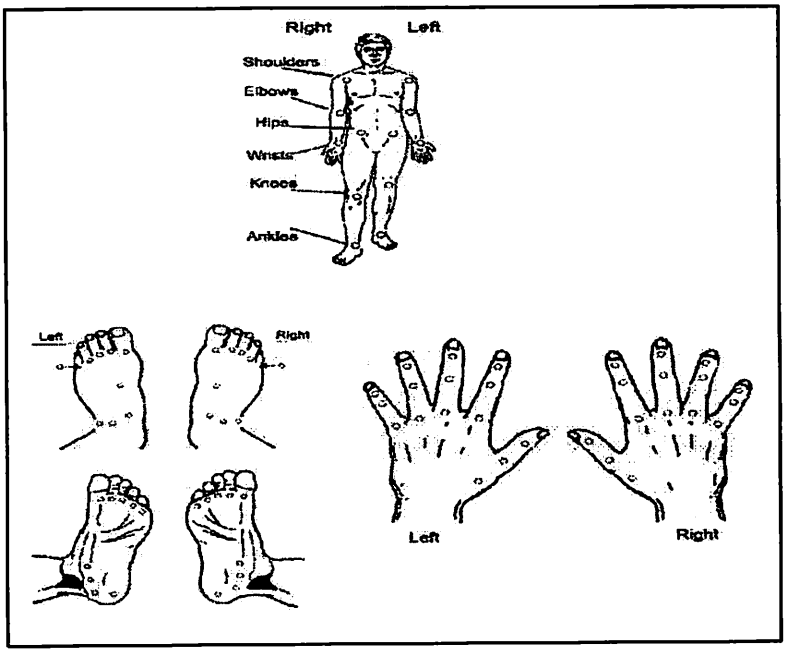
Legal Representative Signature _____

Date_____

TARRANT ARTHRITIS CENTER

Patient History Form

History of present Illness. Please answer each of the following 10 questions and please indicate all the locations of your pain over the past week on the body figures and hands and feet.



1. Location of the problems
   - o All my joints
   - o All my muscles
   - o Head
   - o Scalp
   - o Neck
   - o Right/Left Shoulder
   - o Right/left elbow
   - o Right/left hand
   - o Upper / middle / lower back
   - o Right/left hip
   - o Right/left knee
   - o Right/left ankle
   - o Right/left feet
   - o Others

2. On the scale of 1-10, with 10 being the most severe, circle the number that best describes the problem

   |--------|--------|--------|--------|----|--------|--------|--------|--------|--------|
   0 1 2 3 4 5 6 7 8 9 10

3. When did you first notice the problem? (Circle one) 2 days ago 2 weeks ago 1 month ago 1 year ago 5 years ago, Other _____
4. How long the problem last? (Circle one) 5-15 mins 16- 30 mins 1-2 hours always there
   Other _____
5. When is the problem the worst? (Circle One) Morning end of the day Night No relations to any specific time
   Other _____
6. Does anything make the problem worse? Y N
   If yes, moving around walking sitting standing up driving lying on my side
   Other _____
7. Does anything help or make the problem better? Y N
   If yes, please explain _____
8. Is anything else occurring at the same time? Y N
   If Yes, N a u s e a rash headaches fever tinging swelling stiffness
   Others _____
9. Is the problem constant or variable?
   Dull the sharp very sharp then leaves Dull then throbbing constant
   Other _____
10. Does the problem interfere with your normal functions? Y N

If yes, please explain

_____

TARRANT ARTHRITIS CENTER

Primary Care Provider Name and Phone Number:

Name: _____ **Phone#:** _____

Pharmacy:

Name: _____ **Phone#:** _____

Allergies to medications or x-ray dye:

_____ _____

_____ _____

_____ _____

Medications:

Medication name	Dosage	Frequency

TARRANT ARTHRITIS CENTER

PAST MEDICAL HISTORY

Please check if you have a personal history of any of the following:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Tuberculosis
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Diverticulosis
- ☐ Congestive Heart Failure
- ☐ Anemia
- ☐ Colitis
- ☐ Psoriasis
- ☐ Iritis/Uveitis
- ☐ Sarcoidosis
- ☐ COPD/Emphysema
- ☐ Other

Other:

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

PAST SURGICAL HISTORY

Please check if you have had any of the following surgeries:

- ☐ CABG
- ☐ Nephrectomy
- ☐ Gastric Bypass
- ☐ Bariatric Procedure
- ☐ Hip replacement L / R
- ☐ Knee replacement L / R
- ☐ Kidney Transplant
- ☐ Spine Low / Mid / Cervical (Neck)

FAMILY HISTORY:

Please list any close relative with the following medical conditions:

- ☐ Osteoporosis _____
- ☐ Osteoarthritis _____
- ☐ Rheumatoid Arthritis _____
- ☐ Gout _____
- ☐ Lupus/SLE _____
- ☐ Connective tissue disease _____
- ☐ Psoriasis _____
- ☐ Heart Disease _____
- ☐ Other _____

TARRANT ARTHRITIS CENTER

SOCIAL HISTORY:

Do you smoke? Yes / No Packs per day _____ Previous Smoker? Yes / No Year Quit _____

Do you drink Alcohol? Yes / No How many drinks? _____ Frequency? _____

Illicit Drug use: _____

REVIEW OF SYSTEMS:

Constitutional	☐ Chills	☐ Fever	☐ Weight gain	☐ Weight loss
	☐ Fatigue			
Allergy	☐ Itching	☐ Sneezing	☐ Watery Eyes	☐ Recurrent infection
Eyes	☐ Blurry vision	☐ Dry Eyes	☐ Redness/itching	☐ Eye Pain
Ears, Nose, Mouth	☐ Hearing loss	☐ Dry Mouth	☐ Ringing in the ears	☐ Sore throat
	☐ Swollen glands			
Endocrine	☐ Excessive thirst			
Respiratory	☐ Cough	☐ Shortness of breath	☐ Wheezing	
Cardiovascular	☐ Chest Pain	☐ Irregular heart beat	☐ Swollen hands or feet	
Gastrointestinal	☐ Abdominal pain	☐ Constipation	☐ Diarrhea	☐ Vomiting
Hematology Lymphatic	☐ Anemia	☐ Blood clots	☐ Use of blood thinners	☐ Easy bruising
Urinary	☐ Blood in urine	☐ Frequent urination		
Musculoskeletal	☐ Joint stiffness	☐ Painful joints	☐ Weakness	
Skin	☐ Discoloration	☐ Dry Skin	☐ Hair loss	☐ Nodule
	☐ Rash			
Neurologic	☐ Dizziness	☐ Headache	☐ Tingling/numbness in hands or feet	☐ Tremor
Psychiatric	☐ Anxiety	☐ Depression	☐ Difficulty Sleeping	

TAC
Tarrant Arthritis Center

Receipt of Notice of Private Practice

I, _____, have received the copy of Tarrant Arthritis Notice of Private Practice.

Patient Signature _____ Date: _____

Patient request regarding release of medical records

By completing and signing this document I hereby give permission to Tarrant Arthritis center to disclose as well as to discuss any Protected Health information related to my Health condition(s) to following people

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ I do not wish to disclose my Protected Health Information to anyone besides myself regarding my medical condition.

Patient Signature _____Date: _____

Revised 01/2025

CONSENT FOR MEDICAL CARE AND TREATMENT

I understand that I may have a medical condition that could require examination, diagnosis and treatment and other medical services which may include x-rays, laboratory procedures, tests and medications. I do hereby voluntarily consent to such examination, diagnosis, treatment, and other medical services, and procedures that may be recommended under the general and specific instructions of the physicians of Tarrant Arthritis Center, their assistants, nurses or designees. I acknowledge that the practice of medicine is not an exact science and that the physicians of Tarrant Arthritis Center have made no guarantees to me as to the result of examination, diagnosis, treatment or other medical services.

It is the policy of Tarrant Arthritis Center to participate in or support clinical research designed to use patient data to improve diagnosis and treatment of medical illnesses and to identify potential study subjects for clinical research; such research support may include the review or disclosure of a patient's medical records to research staff unless you indicate you do not consent.

INFORMED CONSENT FOR PRESCRIPTIONS

Tarrant Arthritis Center continues its position as the network exchange for the flow of vital patient information to physicians and other health care providers. It is essential to improve patient safety and the continuity of care with electronic connectivity between payers, physicians and pharmacists. Tarrant Arthritis Center electronic health record (EHR) provides secure access for patients with prescription coverage in the United States.

Prescription eligibility, benefit, formulary and medication history information is provided for consenting patients to authorized physicians at the point of care. Electronic prescriptions are delivered in real-time to pharmacists in retail and mail order settings.

I consent to electronic prescriptions and acknowledge that Tarrant Arthritis Center will use electronic connectivity between payers, physicians and pharmacists.

PATIENT PORTAL CONSENT

Tarrant Arthritis Center is offering the patient portal as a convenience to you. The patient portal is a secure web portal that allows you, as a patient, to view your medical chart and to access our online bill pay via the internet. It also allows you to communicate with our office via secure messaging. You may request appointments, schedule changes, and medication refills (not including controlled substances).

Tarrant Arthritis Center reserves the right to suspend or terminate the patient portal at any time and for any reason.
I understand that the patient portal will be offered at no charge and acknowledge that communications over the internet using the portal is secure. I also agree to the policy defined herein for suspension or termination of portal access.

Signature of Patient or legal Representative _____Date_____

TARRANT ARTHRITIS CENTER

RELEASE OF MEDICAL RECORDS

Patient Name: _____Date of Birth: _____

Social Security #: _____

Patients Phone #: _____

I request and authorize: _____To release the medical record of the above-named patient to:

Name of recipient: Tarrant Arthritis Center
Address: 4375 Booth Calloway Road, suite 208, North Richland hills, TX 76180
Telephone number: 817-865-3939
Fax number: 817-865-3846

Reason for Release: Continue medical care

This request and authorization apply to: (check appropriate line)

_____Healthcare information relating to the following treatment, condition, or dates of treatment: _____

Please send Face sheet, H&P, Consultation notes, Discharge Summary, Laboratory results, and Radiology reports.

_____All healthcare information including information relating to HIV/AIDS testing, sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use.

_____All healthcare information excluding information relating to HIV/AIDS testing, sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use.

_____

Signature of patient or authorized representative Date
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative)

Revised 01/2025

RAPID
ROUTINE ASSESSMENT OF PATIENT INDEX DATA

The RAPID3 includes a subset of core variables found in the Multi-dimensional HAQ (MD-HAQ). Page 1 of the MD-HAQ, shown here, includes an assessment of physical function (section 1), a patient global assessment (PGA) for pain (section 2), and a PGA for global health (section 3). RAPID3 scores are quickly tallied by adding subsets of the MD-HAQ as follows:

1. Please check the **ONE** best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	without ANY difficulty	with SOME difficulty	with MUCH difficulty	UNABLE to do
a. Dress yourself, including tying shoelaces and doing buttons?	___ 0	___ 1	___ 2	___ 3
b. Get in and out of bed?	___ 0	___ 1	___ 2	___ 3
c. Lift a full cup or glass to your mouth?	___ 0	___ 1	___ 2	___ 3
d. Walk outdoors on flat ground?	___ 0	___ 1	___ 2	___ 3
e. Wash and dry your entire body?	___ 0	___ 1	___ 2	___ 3
f. Bend down to pick up clothing from the floor?	___ 0	___ 1	___ 2	___ 3
g. Turn regular faucets on and off?	___ 0	___ 1	___ 2	___ 3
h. Get in and out of a car, bus, train, or airplane?	___ 0	___ 1	___ 2	___ 3
i. Walk two miles or three kilometers, if you wish?	___ 0	___ 1	___ 2	___ 3
j. Participate in recreational activities and sports as you would like, if you wish?	___ 0	___ 1	___ 2	___ 3
k. Get a good night's sleep?	___ 0	___ 1.1	___ 2.2	___ 3.3
l. Deal with feelings of anxiety or being nervous?	___ 0	___ 1.1	___ 2.2	___ 3.3
m. Deal with feelings of depression or feeling blue?	___ 0	___ 1.1	___ 2.2	___ 3.3

1. a-j FN (0-10):

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

2. PN (0-10):

3. PTGE (0-10):

RAPID3 (0-30)

2. how much pain have you had because of your condition **OVER THE PAST WEEK?** Please indicate below how severe your pain has been:

NO PAIN — PAIN AS BAD AS IT COULD BE

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

3. considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL — VERY POORLY

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

CONVERSION TABLE

Near Remission (NR): 1=0.3; 2=0.7; 3=1.0
Low Severity (LS): 4=1.3; 5=1.7; 6=2.0
Moderate Severity (MS): 7=2.3; 8=2.7; 9=3.0; 10=3.3; 11=3.7; 12=4.0
High Severity (HS): 13=4.3; 14=4.7; 15=5.0; 16=5.3; 17=5.7; 18=6.0; 19=6.3; 20=6.7; 21=7.0; 22=7.3; 23=7.7; 24=8.0; 25=8.3; 26=8.7; 27=9.0; 28=9.3; 29=9.7; 30=10.0

TAC
Tarrant Arthritis Center

Tarrant Arthritis Center

Main Office: 7570 N Beach St, Suite 106, Fort Worth TX 76137
Mid-Cities location: 4375 Booth Calloway Rd., Suite 208, NRH, TX 76180
Phone: 817-865-3939 Fax: 817-865-3846

NO-SHOW and LATE CANCELLATION FEE

Effective 01/01/2024

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours' notice. If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess **a $50 "no-show"** service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

_____ _____

Patient Name DOB

_____ _____

Signature Date

Annual questionnaire

Once a year, all our patients are asked to complete this form because drug and alcohol use can affect your health as well as medications you may take.
Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

Alcohol: One drink =

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○