Rheumatology Associates, S.C.

Robert S. Katz, M.D.
Alexandra Katz Small, M.D.
Ben J. Small, M.D.

Mission Statement

To provide unsurpassed patient care and education and to conduct exceptional research.

By continuing to develop clinical and research expertise, maintaining local and national recognition for quality of care, and generating resources to ensure excellent service and foster growth.

Through a dedicated staff who care about our patients and each other and are committed to providing quality and uncompromising personal service.

Rheumatology Associates, S.C.

Rush Address:
1725 West Harrison St., Rush Professional Bldg., Suite 365, Chicago, Illinois 60612
Northwestern Address:
676 N. St. Clair, Arkes Family Pavillion, Suite 1717, Chicago, Illinois 60611

Rheumatology
Telephone: 312–226–8228
Fax: 312–226–5572

Welcome to Rheumatology Associates, S.C.

Please fill out the enclosed forms and bring them with you to your appointment.

We look forward to seeing you.

Sincerely,

Robert S. Katz, M.D.
Alexandra Katz Small, M.D.
Ben J. Small, M.D.

Robert S. Katz, M.D.

- Master - American College of Rheumatology Award
- Professor of Medicine, Rush Medical College
- Professor of Medicine, Northwest University's Feinberg School of Medicine
- Senior Attending Physician, Rush University Medical Center and Northwestern Hospital
- B.A., Columbia University, NY
- M.D., University of Maryland
- Internal Medicine Internship and Residency, Barnes Hospital, Washington Univ. School of Medicine, St. Louis
- Rheumatology Fellowship, Johns Hopkins Medical School
- *U.S. News and World Report*, recognized as Top 1% of Rheumatologists in the U.S. 2012-
- *Castle Connolly Guide "America's Best Doctors",* 1999-2019 (National and Chicago Editions)
- *Best Doctors in America* (Woodward and White, Publishers)
- "Chicago's Top Doctors", *Chicago Magazine,* all "best doctors" issues, 2004-2019
- *Guide to Top Doctors*, all editions
- *Leading Physicians of the World*, 2013-2019
- Editorial Board, *Journal of Clinical Rheumatology*
- Chair, Abstract Selection Committee, American College of Rheumatology
- Editorial Review, *Arthritis & Rheumatism, Journal of Rheumatology, Journal of Clinical Rheumatology, Arthritis Care and Research*
- Chair, Medical Advisory Board, Lupus Foundation of Illinois
- Board Member, Lupus Foundation of Illinois
- Board Member, Lupus Research Institute
- Board Member, Arthritis Foundation
- Professional Achievement Awards, Lupus Foundation of Illinois
- Former Medical Editor, WBBM TV, WFLD TV; Reporter, CNBC TV
- Former Chair, *Chicago Sun-Times* Medical Advisory Board
- Former Chair, Medical & Scientific Committee, Arthritis Foundation
- Former President, Chicago Rheumatism Society
- R.S. Katz, M.D. and Rubschlager Chair for Arthritis Research, Rush Medical College
- Public Service Award and Professional Achievement Award, Arthritis Foundation
- The Institute of Medicine, Fellow 2014-
- Patient Choice Award 2009-2019
- Compassionate Doctor Award 2011-2019
- Written more than 300 original academic research abstracts and papers
- Conducted over 100 research studies on new medications in rheumatology
- Rheumatologist, Chicago White Sox

RHEUMATOLOGY ASSOCIATES, S.C.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, **Rheumatology Associates, S.C.** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare organizations (TPO). Please refer to **Rheumatology Associates, S.C.** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent.

Rheumatology Associates, S.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Carlen Katz, Privacy Officer, at 1725 West Harrison Street, Suite 365, Chicago, Illinois 60612.

With my consent, **Rheumatology Associates, S.C.** may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, **Rheumatology Associates, S.C.** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential.

With my consent, **Rheumatology Associates, S.C.** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Rheumatology Associates, S.C.** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the use and disclosure of my PHI by **Rheumatology Associates, S.C.** to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Rheumatology Associates, S.C.** may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

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PATIENT INFORMATION

Name Last First M.I.

Maiden Name (if applicable) Sex ❑ Male ❑ Female

Address

City State Zip Code

Phone Home ( ) Work ( ) Cell Phone ( )

E-mail Address

Social Security Number Date of Birth Birthplace

REFERRAL INFORMATION

Primary Care Doctor Phone ( )

Address

Other Physicians (OBGYN, Ortho, other) Phone ( )

Address

Referring Doctor Phone ( )

Address

EMERGENCY INFORMATION (person to be contacted in case of emergency)

Name Last First M.I.

Relationship to Patient

Phone Home ( ) Work ( )

EMPLOYMENT INFORMATION

Occupation

Employer Name

Address

Phone ( )

HEALTH PLAN #1

Member Name Last First M.I.

Relationship to Patient Member SSN

Group Number Policy Number

Company Name

Address

Phone ( ) Effective Date

HEALTH PLAN #2

Member Name Last First M.I.

Relationship to Patient Member SSN

Group Number Policy Number

Company Name

Address

Phone ( ) Effective Date

BILLING INFORMATION

(Who is responsible for bills not covered by the health plan?)

Self ❑ Other ❑ (Please identify below)

Name Last First M.I.

Address

City State Zip Code

Phone Home ( ) Work ( )

Relationship to Patient

WE WOULD LIKE TO KNOW MORE ABOUT YOU.

How long have you been married?

What does your spouse/significant other do?

What do you and your spouse/significant other like to do together in your free time?

What are your hobbies, and how do you spend your leisure time?

AGREEMENT AND AUTHORIZATION

Financial Responsibility: I agree to pay to each of the applicable practices and/or services identified on the face page the established charges of all services, facilities, and supplies provided to me and/or dependents. I understand that payment may be required at the time of services. I agree to pay any balance not paid by my health plan, for whatever reason, subject to the applicable health plan contract. I understand that I will be billed for such services and I agree to make prompt payment regarding the same.

Release of Information: I understand that it is necessary that medical and financial information pertaining to me and my dependents be exchanged among and between the Medical Center, physicians providing services, and insurance companies and/or other paying agencies, and I consent to such exchange of information as may be necessary without further written authorization.

Assignment of Benefits: I hereby assign the Medical Center and physicians providing services to me and my dependents the medical and surgical benefits to which I and my dependents are entitled under my health insurance plan.

Patient Signature Date / /

Patient/Guardian Signature (required when patient is a minor) Date / /

Guarantor Signature (if applicable) Date / /

AMERICAN COLLEGE OF RHEUMATOLOGY

EDUCATION • TREATMENT • RESEARCH

Patient History Form

Date of first appointment: _____/____/_____ Time of appointment: _____ Birthplace: _____
MONTH DAY YEAR

Name: _____ Birthdate: _____/____/_____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: _____ Age: _____ Sex: ❑ F ❑ M
STREET APT#

_____ Telephone: Home (_____)_____
CITY STATE ZIP

Work (_____)_____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ ❑ Major Illnesses _____

Referred here by: (check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: _____

Describe briefly your present symptoms: _____

_____

_____

Date symptoms began (approximate): _____

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later) _____

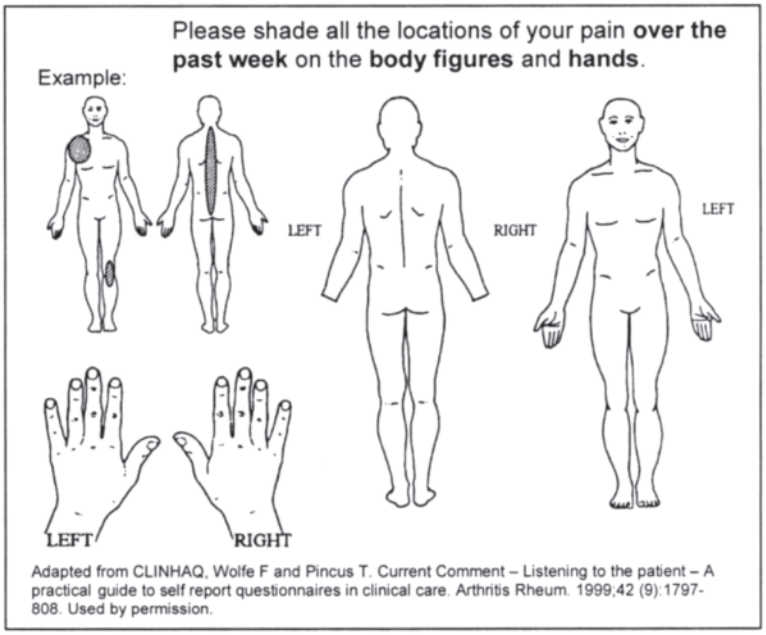
_____

_____

Please list the names of other practitioners you have seen for this. problem: _____

_____

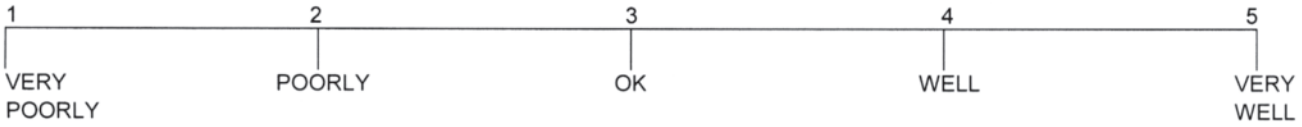
_____



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

Patient's Name _____ Date _____ Physician Initials _____

ACTIVITIES OF DAILY LIVING



What is the hardest thing for you to do?_____

Are you receiving disability?.....Yes ❑ No ❑

Are you applying for disability?.....Yes ❑ No ❑

Do you have a medically related lawsuit pending?.....Yes ❑ No ❑

SYSTEMS REVIEW

Constitutional

❑ Recent weight gain
amount _____

❑ Recent weight loss
amount _____

❑ Fatigue

❑ Weakness

❑ Fever

Eyes

❑ Double or blurred vision

❑ Dryness

❑ Feels like something in eye

Ears–Nose–Mouth–Throat

❑ Loss of hearing

❑ Sores in mouth

❑ Dryness of mouth

❑ Difficulty in swallowing

Cardiovascular

❑ Pain in chest

❑ Irregular heart beat

❑ High blood pressure

❑ Heart murmurs

Respiratory

❑ Shortness of breath

❑ Swollen legs or feet

❑ Cough

Gastrointestinal

❑ Nausea

❑ Vomiting of blood or coffee ground material

❑ Increasing constipation

❑ Persistent diarrhea

❑ Blood in stools

❑ Black stools

❑ Heartburn

Genitourinary

❑ Pain or burning on urination

❑ Blood in urine

Musculoskeletal

❑ Morning stiffness
Lasting how long?
_____ Minutes _____ Hours

❑ Joint pain

❑ Muscle weakness

❑ Muscle tenderness

❑ Joint swelling
List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

❑ Rash

❑ Sun sensitive (sun allergy)

❑ Color changes of hands or feet in the cold

Neurological System

❑ Headaches

❑ Dizziness

❑ Fainting

❑ Memory loss

Psychiatric

❑ Excessive worries

❑ Anxiety

❑ Easily losing temper

❑ Depression

❑ Agitation

❑ Difficulty falling asleep

❑ Difficulty staying asleep

Hematologic/Lymphatic

❑ Swollen glands

Patient's Name _____ Date _____ Physician Initials _____

SOCIAL HISTORY

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago? _____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Do you exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week _____

PAST MEDICAL HISTORY

Do you now or have you ever had: *(check if 'yes')*

❑ Cancer	❑ Stomach ulcers
❑ Nervous breakdown	❑ Asthma
❑ Bad headaches	❑ Stroke
❑ Kidney disease	❑ Epilepsy
❑ Anemia	❑ Colitis
❑ Emphysema	❑ Psoriasis
❑ Heart problems	❑ High Blood Pressure
❑ Diabetes	

Other significant illness (please list) _____

_____

Natural or Alternative Therapies (chiropractic, massage, acupuncture) _____

_____

_____

_____

Previous Operations

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes Describe: _____

Any other serious injuries? ❑ No ❑ Yes Describe: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

_____

Patient's Name _____ Date _____ Physician Initials _____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

_____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking, Include such items as aspirin, vitmanins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the results of taking the medication and list any ***reactions*** you may have had. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-Steriodal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past					
Lodine (etodolac)	Meclomen (meclofenamate)	Feldene (piroxicam)		Celebrex (celecoxib)	
Voltaren (diclofenac)	Aleve	Motrin/Rufen (ibuprofen)		Naprosyn (naproxen)	
Daypro (oxaprozin)	Aspirin (including coated aspirin)	Advil		Mabic (meloxicam)	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Abatacept (Orencia)		❑	❑	❑	
Adalimumab (Humira)		❑	❑	❑	
Anakinra (Kineret)		❑	❑	❑	
Apremilast (Otezla)		❑	❑	❑	
Azathioprine (Imuran)		❑	❑	❑	
Certolizumab (Cimzia)		❑	❑	❑	
Cyclophoshamide (Cytoxan)		❑	❑	❑	
Etanercept (Enbrel)		❑	❑	❑	
Golimumab (Simponi)		❑	❑	❑	
Hydroxychloroquine (Plaquenil)		❑	❑	❑	
Infliximab (Remicade)		❑	❑	❑	
Leflunomide (Arava)		❑	❑	❑	
Methotrexate		❑	❑	❑	
Mycophenolate (Cellcept)		❑	❑	❑	
Rituximab (Rituxan)		❑	❑	❑	
Sulfasalazine (Azulfidine)		❑	❑	❑	
Tocilizumab (Actemra)		❑	❑	❑	
Ustekinumab (Stelara)		❑	❑	❑	
Other		❑	❑	❑	
Fibromyalgia Medications					
Amitriptyline (Elavil)		❑	❑	❑	
Cyclobenzaprine HCl (Amrix, Flexeril)		❑	❑	❑	
Duloxetine (Cymbalta)		❑	❑	❑	
Gabapentin (Neurontin)		❑	❑	❑	
Milnacipran (Savella)		❑	❑	❑	
Pregabalin (Lyrica)		❑	❑	❑	
Doxepin (Sinequan)		❑	❑	❑	
Tizanidine (Zanaflex)		❑	❑	❑	
Trazadone (Desyrel)		❑	❑	❑	
Others					
Other		❑	❑	❑	
Other		❑	❑	❑	