ATTUNE HEALTH

Autoimmune and Inflammation Care and Research

CONSENT TO RELEASE MEDICAL RECORDS

Please fill out only if we need to request records from other Doctors.

Patient name: _____ Home Number: _____

Date of birth: _____ Cell Number: _____

I hereby authorize and request that _____
Name of facility/individual

_____
Address **City/State/Zip** **Phone number and Fax**

Release information from my records to the following:

Name of the Facility/individual: _____

_____
Address City/State/Zip

_____
Fax number, if applicable

Please be specific regarding record and dates requested Information to be released:

Diagnosis and record of treatment _____
Specific date/dates requested

Laboratory and/or X-ray reports _____
Specific date/dates requested

Entire file (excluding confidential and psychiatric records, if any)

Other_____

Be advised that if you are requesting a copy of your medical record, a copying fee shall apply.

It is prohibited by law to release/disclose the attached/enclosed information to anyone except those specified above. I understand that this Authorization alone may not authorize release psychiatric or HIV information.

In signing, I am aware that this Authorization is valid for 30 calendar days after today

_____
Patient Signature Date

DISPOSITION/DATE: Mailed certified/return receipt requested (date) _____
Faxed (date and time) _____ ID verification by_____

Records given to patient / date and time_____ Provider's approval_____

Patient will pick up ☐ Patient Paid: Date:_____

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Dr. Venuturupalli ☐ Dr. Myers ☐ Dr. Scaramangas ☐

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____

Preferred Name (Nickname): _____ Maiden Name:_____

Date of Birth: _____ Sex: _____ Social Security#: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone:_____ Authorized to text?: Yes ☐ No ☐

Work Phone:_____ Email: _____ Authorized to email?: Yes ☐ No ☐

Pharmacy Name/Address/Phone: _____

Employer Name: _____ Occupation: _____

Emergency Contact Name and Phone Number: _____ Relationship: _____

Primary Care Physician: _____ Phone/Fax: _____

How were your referred to the office?: _____

Would you be interested in hearing about a research study?: _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insurance Name: _____ Relationship to Policy Holder: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____ Sex: _____

Policy/ID #: _____ Group #: _____ Effective Date: _____

Claim Address & Phone Number: _____

SECONDARY INSURANCE:

Insurance Name: _____ Relationship to Policy Holder: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____ Sex: _____

Policy/ID #: _____ Group #: _____ Effective Date: _____

Claim Address & Phone Number: _____

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AUTHORIZATION, ASSIGNMENT, AND RELEASE

By signing below, I certify all information provided is true and correct to the best of my knowledge. I authorize payment directly to this physician practice for all medical services otherwise payable to me under terms of my insurance (if applicable). I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred from or to for treatment. A photocopy of this authorization shall be considered as effective and as valid as the original.

Patient Signature: _____ **Date:** _____

PATIENT MEDICAL PROFILE QUESTIONNAIRE

Date: _____ Active MyCSLink User: Yes☐ No☐

Patient Name: _____

What is the special problem(s) or symptom(s) that brings you here for an appointment?

_____

_____

_____

_____

_____

Number of Children: _____. Please list their ages: _____
Occupation: _____
Highest Level of Formal Education: _____

Family History:

Mother: Living ☐ Deceased ☐ Age of Death: _____ Medical History:	Father: Living ☐ Deceased ☐ Age of Death: _____ Medical History:

Do you have any family members with autoimmune diseases? If yes, please list below:

_____

_____

_____

Please list all medications that you take regularly (prescription and nonprescription) with dosages: (You may instead bring in a written medication list)

Medication	Dosage	Medication	Dosage
1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	
8.		16.	

Please list any operations you have had:

Type of operation	Year	Hospital

Please list any non-surgical hospitalizations:

Reason for hospitalization	Year	Hospital

All information on this questionnaire will be kept confidential. It cannot be photocopied without your written consent.

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Autoimmune	**YES**	**NO**
1. Have you experienced dry eyes for 3 months or longer?	☐	☐
2. Have you experienced dry mouth for 3 months or longer?	☐	☐
3. Have you had a lot of hair fall out recently?	☐	☐
4. Do you get oral ulcers?	☐	☐
5. Are you troubled by stiff or painful joints?	☐	☐
6. Are your joints ever swollen?	☐	☐
7. Do you often get a rash on your cheeks?	☐	☐
8. Are you sensitive to sunlight?	☐	☐
9. Do your fingers turn different colors in cold weather? (Raynaud's)	☐	☐
10. Have you ever had pleurisy or pericarditis?	☐	☐
11. Have you ever been told that you had protein in your urine?	☐	☐
12. Have you ever had a positive blood test for ANA (antinuclear antibody)? Or any abnormal blood test? If so, specify.	☐	☐
Constitutional		
13. Have you recently lost weight?	☐	☐
14. Do you often feel exhausted or fatigued?	☐	☐
15. Do you frequently run low-grade fevers?	☐	☐
ENT	☐	☐
16. Have you had intermittent swelling of your salivary glands?	☐	☐
17. Is it difficult or painful for you to swallow?	☐	☐
Skin	**YES**	**NO**
18. Do you have any skin conditions? If yes, please list below.	☐	☐

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19. Have you ever been told you have psoriasis?	☐	☐
Respiratory		
20. Do you wheeze or gasp to breathe?	☐	☐
21. Do you wheeze or feel short of breath?	☐	☐
22. Do you have sleep apnea?	☐	☐
M**usculoskeletal**		
23. Do you have osteoporosis?	☐	☐
24. Have you been told by a doctor that you have Fibromyalgia? Myofascial Pain Syndrome)?	☐	☐
25. Are you bothered by lower back pain?	☐	☐
26. Have you been diagnosed with gout or pseudogout?	☐	☐
Cardiovascular		
27. Do you ever get pain or tightness in your chest?	☐	☐
28. Are you troubled by swollen feet or ankles?	☐	☐
29. Do you have high blood pressure (hypertension)?	☐	☐
Psychiatric		
30. Have you ever desired or sought psychiatric help? If yes, for what?	☐	☐
31. Do you ever have difficulty falling or staying asleep?	☐	☐
32. Do you usually feel lonely or depressed?	☐	☐
33. Do you have bipolar disorder?	☐	☐
34. Do you have difficulty relaxing?	☐	☐
Neurological		
35. Do you have frequent headaches?	☐	☐
36. Is any part of your body numb?	☐	☐
37. Are you troubled by dizzy spells or lightheadedness?	☐	☐
	YES	**NO**

38. Have you ever had a seizure or a stroke?	☐	☐
39. Do you have any visual changes?	☐	☐
Gastrointestinal		
40. Are you troubled by heartburn?	☐	☐
41. Do you easily become nauseated?	☐	☐
42. Do you have gas or bloating?	☐	☐
43. Have you been diagnosed with Crohn's or Ulcerative Colitis?	☐	☐
44. Are bowel movements often loose?	☐	☐
45. Are your bowel movements ever black or bloody?	☐	☐
46. Are you often constipated?	☐	☐
Hematologic		
47. Have you ever had low Vitamin B_{12}, low iron, or bone marrow disorder? If yes, please specify:	☐	☐
48. Have you ever been treated for a blood clot with blood thinners?	☐	☐
49 Have you ever had cancer of any kind? If yes, what kind? When and where were you diagnosed?	☐	☐
50. Have you ever been told that you were anemic?	☐	☐
51. Have you ever had low white blood cell count? If yes, do you have(check all that apply): a) Low iron, b)low B12, c)heavy periods, d)anemia of chronic disease e)bleeding ulcers, f)anemia due to medication g)hemolytic anemia, h)other,(specify)	☐ ☐	☐ ☐
52. Have you ever had low platelets counts?	☐	☐
53. Have you ever had idiopathic thrombocytopenia purpura (ITP)?	☐	☐
54. Have you been told by a doctor that you have antiphospholipid syndrome?	☐	☐
Allergy/Infection	**YES**	**NO**

55. If you are allergic to any medication or food, please list with reaction:		☐	☐
56. Have you ever had Hepatitis?		☐	☐
57. Have you ever had a positive skin test or blood test for TB?		☐	☐
58. Do you get sick frequently?		☐	☐
MISC			
59. Do you smoke cigarettes currently? Have you smoked in the past? If so, please specify duration of time (in years).		☐	☐
60. Are you using birth control? If yes, what?		☐	☐
61. Fill in the number of each of the following if applicable:			
Pregnancies	Children Born Alive		
Premature births	Stillbirths		
Abortions	miscarriages		

Is there anything important in your medical history that we did not ask which might be useful for the doctors to know?

_____

_____

_____

_____

_____

OFFICE POLICIES/AGREEMENT

Financial agreement - As the responsible party, you are responsible if your insurance company declines to pay for any reason.