BEALS INSTITUTE

WELCOME TO THE BEALS INSTITUTE

The Beals Institute health care providers are committed to bringing you a quality of excellence in health care. Our areas of focus are arthritis, osteoporosis, musculoskeletal, autoimmune, and related diseases.

- Your visit and services will focus on evaluation of your current health problem and resolution for that problem.
- Review of labs, x-rays, and special studies that pertain to your specific problem.
- Evaluation of your current health care plan, to plan for future care and prevention of new health problems, and to guide the patient in becoming knowledgeable and self empowered to direct their own health care.

BEALS INSTITUTE

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Office hours by appointment only

Phone (517) 321-1525

Beals Institute
4333 W. St. Joe Hwy.
Lansing, Michigan 48917

Welcome to our office. Our goal is for you to receive state of the art health care. We would like to take this opportunity to explain our office policies.

- We are committed to assisting our patients in utilizing their health insurance plans but with greater than 100 plans in existence, you must be the one who is the expert on your plan.

- Beals Institute participates in select insurance carriers and HMO's. We recommend that you verify our participation in your plan. We will bill eligible services to your primary insurance carrier.

HMO/PPO PLANS: You must provide written authorization from your primary care physician for your visit. You will be held responsible for any unauthorized services.

- If you have an insurance other than those we participate with, we will complete claim forms for diagnostic test and procedures. It is the patient's responsibility to collect payment from their insurance carrier.

FEES FOR OUR SERVICES

- Fee schedules are available. Please ask. Fees are based on the complexity of the problem, complexity of the problem solving, the number of problems, and insurance criteria. Office visits provided by Nurse Practitioners are the same fees as the physician or per Medicare and insurance regulations.

- Appointments cancelled without a notice of 1 business day will be subject to a cancellation charge of $100 for a new patient and $25 or more for a return visit.

- After your second visit services when your condition is stable, your care may be provided by a Nurse Practitioner or Physician's Assistant. All care provided is in coordination with the physicians.

- Nurse Practitioners and Physician's Assistants are Master's Degree educated in advanced health care. They are specifically further trained in rheumatology by our staff physicians.

Your new patient appointment is scheduled for:

Date:_____

Time:_____am/pm

With: _____

Please call (517) 321-1525 to confirm your visit at least 2 business days prior to your visit.

Please have all insurance cards, authorizations, and picture identification available at check in.

Bring any recent lab or x-rays and a list of your current medications.

Thank you for selecting the Beals Institute for your quality medical care in arthritis and related care.

BEALS INSTITUTE, P.C.

ARTHRITIS, OSTEOPOROSIS AND AUTOIMMUNE DISEASES

4333 W. St. Joe Hwy, Lansing, MI 48917 • (517) 321-1525 • Fax (517) 321-7059

Thank you for choosing the Beals Institute. We would like to take this opportunity to acquaint you with our practice and provide you with some useful information before your visit.

1. Your First Visit

- Plan to arrive about 15 minutes early to fill out any paperwork.
- First visits may last up to 1-2 hours so please bring a book and/or a snack.
- Please remember that emergencies do occur and may delay your appointment.

* Please refrain from wearing any scented lotions or perfumes to your appointments or you may be rescheduled.

2. What To Bring

- Please bring your driver's license, all insurance information (including the cards), recent labs and x-ray reports and a list of your current medications.
- Please bring the enclosed new patient information filled out. It will speed up the check-in process if this information is complete.
- If your insurance requires an authorization, it is YOUR responsibility to contact your primary care physician and complete. Please check with your insurance to verify coverage, deductibles, and co-pays. Our staff will be happy to answer any questions regarding our physicians participation in the various insurance plans.
- **ALL CO-PAYS ARE DUE AND PAYABLE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA AND MASTERCARD.**

**** I understand that this office does not participate in Worker's compensation, No Fault Insurance, or any Auto Injury related cases and I will be responsible for payment if this visit is a result of such.**

I acknowledge that I have had the opportunity to receive a copy of this office's Notice of Privacy Practices.

_____ _____

Printed Name of Patient or Guardian Date

_____ _____

Signature of patient or guardian Date of Birth

There are continuously medical students, interns, resident, and fellows present in our clinic. These are doctors in training and work in the clinic under our supervision. We request your willingness to allow their participation in your care, and we assure you that they are closely monitored by us, and are capable of participating. It has been our experience that the teaching atmosphere improves the environment in our clinic, and actually improves the overall benefit to our patients.

We hope your visit with us is a pleasant one. If there is anything we can do to make your first visit more smooth, please do not hesitate to call us at 517-321-1525.

Thank you,

Beals Institute Scheduling Staff

Patient History Form

Date of First appointment: _____/_____/_____ Time of appointment: _____ am / pm

Name: _____ Birth Date _____/_____/_____
Last First MI Maiden Month Day Year

Address: _____ Age: _____ Sex: F ☐ M ☐
Street Apt #

_____ Telephone: Home ( ) _____
City State Zip Work ( ) _____
Cell ( ) _____

Employer: _____

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Name of spouse/partner: _____ DOB: _____

Spouse/Partner employed by: _____

If minor, Mother's Name: _____ DOB: _____

Father's Name: _____ DOB: _____

Patient Education (Circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of Hours worked/average per week _____

Have you missed time at work due to illness and/or pain in the last year? ☐ No ☐ Yes If so, How much? _____

Name of referring Doctor: _____

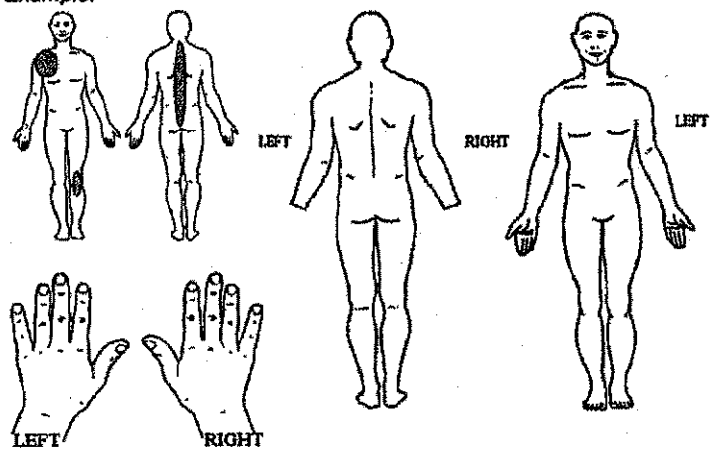
Name of Primary Care Doctor: _____

Briefly describe your present symptoms: _____
_____
_____
_____
_____
_____
_____

Approximate Date symptoms began:
_____
_____

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:



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 (8):1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

*At any time have you or a blood relative had any of the following? (Check if "YES")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relations
	Arthritis (Unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions: _____					

Patient Name_____ DOB_____ Date_____

Continuation sheet

Date:	Wt: Ht: BP: P: R: GSR: GSL:

WELCOME TO THE BEALS INSTITUTE

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Beals Institute to release any medical or incidental information that may be necessary for either medical care or in processing applicants for financial benefits.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of surgical/medical benefits to Beals Institute for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I certify that the information given by me on the pages below is current and correct. I request that payment of authorized benefits be made on my behalf. I have reviewed and agree with the Beals Institute privacy practices and financial policies.

Patient Name_____ DOB_____ Date_____

RACE

_____ American Indian or Alaska Native

_____ Asian

_____ Black or African American

_____ White

_____ Native Hawaiian

_____ More than one race

_____ Decline to report

ETHNICITY

_____ Hispanic or Latino

_____ Not Hispanic or Latino

_____ Decline to report

PREFERRED LANGUAGE

_____ Spanish

_____ English

_____ Other _____

Local Pharmacy _____

Mail-In Pharmacy _____

E-Mail Address _____

Patient Name _____ DOB _____ Date _____

SOCIAL HISTORY

Do you drink caffeinated beverages? ☐ Yes ☐ No
If yes, what type? _____
How many servings per day? _____
Do you smoke currently? ☐ Yes ☐ No
If yes, How many packs/day? _____
How long? _____
If quit, how many packs were you smoking? _____
When did you quit smoking? _____
Do you drink alcohol? ☐ Yes ☐ No
If yes, how many drinks per day? _____, per week? _____
Do you use drugs for purposes other than for medical reasons? ☐ Yes ☐ No
If yes, please list: _____
_____
Do you have a medical marijuana card? ☐ Yes ☐ No
Do you have a home exercise program that you do on a regular basis? ☐ Yes ☐ No
If yes, what is it? _____
How often do you exercise? _____

PREGNANCY HISTORY

Do you have children? ☐ Yes ☐ No
If so, what year(s) were they born? _____
# of times pregnant: _____ # of deliveries: _____ Miscarriages/abortions: _____
# of living children: _____ # of deceased children: _____
Are you currently pregnant? ☐ Yes ☐ No
Birth control Method: _____

FAMILY HISTORY (Please mark appropriate numbers for family members)

(1) High Blood Pressure	(2) Heart disease	(3) Epilepsy/seizures	(4) Diabetes	(5) Cancer	(6) Asthma
(7) Hay fever/allergies	(8) Arthritis	(9) Kidney disease	(10) Glaucoma	(11) Stroke	(12) Migraine
(13) Mental illness	(14) Alcoholism	(15) Bleeds easily	(16) Anemia	(17) Psoriasis	(18) Eczema
(19) Osteoporosis	(20) Obesity	(21) Blindness	(22) Deaf	(23) Mental Retardation	

Family Member	Alive	Deceased	#'s that apply	Cause of death/age
Father				
Mother				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Mother's Mom				
Mother's Dad				
Father's Mom				
Father's Dad				

IMMUNIZATIONS (Please write year of last injection)

_____ Pneumonia _____ Flu (Influenza) _____ Tetanus _____ Shingles _____ Mumps

_____ Diptheria _____ Measles _____ Rubella _____ Hepatitis _____ Other

Patient Name_____ DOB_____ Date_____

Drug Allergies: _____

_____

Food/Environmental Allergies: _____

_____

Current Medications (list **ALL** medications that you are currently taking, including vitamins, supplements and over-the-counter medications etc)

Name of Medication	Dosage/mg	Frequency/How often medication is taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Past Medical History- Do you now or have you ever had: (circle if "yes")

Cancer	Heart problems	GERD	Asthma	Goiter
Leukemia	Stroke	Cataracts	Diabetes	Epilepsy
Nervous Breakdown	Stomach Ulcers	Rheumatic Fevers	Headaches	Jaundice
Colitis	Kidney Disease	Pneumonia	Psoriasis	Anemia
HIV/AIDS	Emphysema	High Blood Pressure	Glaucoma	Tuberculosis
Weakness in arms/legs	Seizures	Night sweats	Loss of appetite	Change of taste in food

Difficulty controlling bowel/bladder function

Other significant illnesses (please list) _____

_____

Patient Name _____ DOB _____ Date _____

Past Medications: Please review this list of medications. Please (√) **YES** or **NO** to whether you have ever taken each medication in the past and whether it was helpful or not. If discontinued, please write the reason why. Please only mark the medications you have tried but are **NOT CURRENTLY TAKING**.

MEDICATION	Taken		Tolerated		Helpful		REASON DISCONTINUED
	YES	NO	YES	NO	YES	NO	
NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)							
Naproxen (Aleve)							
Ibuprofen (Motrin/Advil)							
Ketoprofen							
Oxaproxin (Daypro)							
Diclofenac (Voltaren)							
Indomethacin (Indocin)							
Ketorolac (Toradol)							
Etodolac (Lodine)							
Sulindac (Clinoril)							
Meloxicam (Mobic)							
Celebrex (Celecoxib)							
Salsalate (Disalcid)							
Nabumetone (Relafen)							
Other:							
PAIN RELIEVERS							
Acetaminophen (Hydrocodone/Tylenol)							
Codeine (Vicodin/ Tylenol #3)							
Darvocet/Darvon							
Tramadol (Ultram/Ultracet)							
Other:							
DISEASE MODIFYING ANTIRHEUMATIC DRUGS (DMARDs)							
Plaquenil (Hydroxychloroquine)							
Methotrexate							
Arava (Leflunomide)							
Imuran (Azathioprine)							
Sulfasalazine (Azulfadine)							
Quinacrine (Atabrine)							
Cyclophosphamide (Cytoxan)							
Enbrel							
Humira							
Remicade							
Other:							
GOUT MEDICATIONS							
Allopurinol (Zyloprim)							
Colchicine (Colcrys)							
Probenecid (Benemid)							

Patient Name _____ DOB _____ Date _____

MEDICATION	Taken		Tolerated		Helpful		REASON DISCONTINUED
	YES	NO	YES	NO	YES	NO	
OSTEOPOROSIS MEDICATIONS							
Estrogen (Premarin, etc)							
Alendronate (Fosamax)							
Evista (Raloxifene)							
Actonel							
Prolia							
Forteo							
Reclast							
ANTI-CONVULSANTS							
Gabapentin (Neurontin)							
Lyrica (Pregabalin)							
Topamax (Topiramate)							
Lamictal (Lamotrigene)							
MUSCLE RELAXERS							
Methocarbamol (Robaxin)							
Orphenadrine (Norflex)							
Tizanidine (Zanaflex)							
Metaxalone (Skelaxin)							
Baclofen (Lioresal)							
Cyclobenzaprine (Flexeril)							
Carisoprodol (Soma)							
ANTI-DEPRESSANTS							
Amitriptyline (Elavil)							
Nortriptyline (Pamelor)							
Fluoxetine (Prozac)							
Paroxetine (Paxil)							
Venlafaxine (Effexor)							
Duloxetine (Cymbalta)							
Milnacipran (Savella)							
Buspirone (Buspar)							
Velazodone (Viibryd)							
Bupropion (Wellbutrin)							
Escitalopram (Lexapro)							
Citalopram (Celexa)							
OTHERS							
Cortisone (Prednisone)							
Hyalgan, Euflexxa, Synvisc, Supartz, etc							
Herbal or Nutritional Supplements							

Patient Name_____ DOB_____ Date_____

DIAGNOSTIC TESTS

Which of the following diagnostic tests have been done? Please indicate date for "yes" answers. Please state if you have been unable to complete any of these tests, or if you have had a severe reaction to any of them:

	Approximate Date	Reason testing not complete
Spine X-Rays (L, C, T-spine)	_____	_____
CT Scan	_____	_____
Myelogram	_____	_____
MRI Scan	_____	_____
Bone Scan	_____	_____
EMG	_____	_____
Nerve Block	_____	_____

PREVIOUS INJURIES, OPERATIONS OR HOSPITAL ADMISSIONS

	Type	Date/Year	Where/location	Reason
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				
11)				
12)				
13)				
14)				
15)				

***Please list the physicians and/or chiropractors you have seen for your pain, along with the approximate dates.**

Type of doctor	Doctor's Name	Location	Approximate Date

Patient Name _____ Date of Birth _____ Date _____

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram _____/_____/_____ Date of last eye exam _____/_____/_____ Date of last chest x-ray_____/_____/_____

Date of last Tuberculosis Test _____/_____/_____ Date of last Bone Density Test _____/_____/_____

Constitutional
☐ Recent weight gain
Amount _____
☐ Recent weight loss
Amount _____
☐ Fatigue
☐ Weakness
☐ Fever

Eyes
☐ Pain
☐ Redness
☐ Loss of vision
☐ Double or blurred vision
☐ Dryness
☐ Feels like something in eye
☐ Itching eyes

Ears, Nose, Mouth, Throat
☐ Ringing in ears
☐ Loss of hearing
☐ Nosebleeds
☐ Loss of smell
☐ Dryness in nose
☐ Runny nose
☐ Sore tongue
☐ Bleeding gums
☐ Teeth grinding
☐ Sores in mouth
☐ Loss of taste
☐ Dryness in mouth
☐ Frequent sore throats
☐ Hoarseness
☐ Difficulty swallowing

Cardiovascular
☐ Pain in chest
☐ Irregular heart beat
☐ Sudden changes in heart beat
☐ High blood pressure
☐ Heart murmur

Respiratory
☐ Shortness of breath
☐ Difficulty breathing at night
☐ Swollen legs or feet
☐ Cough
☐ Coughing up blood
☐ Wheezing (asthma)

Gastrointestinal
☐ Nausea
☐ Vomiting of blood or coffee ground material
☐ Stomach pain relived by milk or food
☐ Jaundice
☐ Increasing constipation
☐ Persistent diarrhea
☐ Blood in stools
☐ Black stools
☐ Heartburn

Genitourinary
☐ Difficult urination
☐ Pain or burning on urination
☐ Blood in urine
☐ Cloudy, "smoky" urine
☐ Pus in urine
☐ Discharge from vagina/penis
☐ Getting up at night to pass urine
☐ Vaginal dryness
☐ Rash/ulcers
☐ Sexual difficulties
☐ Prostate trouble

For Women only:
Age when periods began: _____
Periods regular? ☐ Yes ☐ No
How many days apart? _____
Date of last period?____/_____/____
Date of last pap? _____/_____/_____
Bleeding after menopause? ☐ Yes ☐ No
Difficulty getting pregnant? ☐ Yes ☐ No

Musculoskeletal
☐ Morning stiffness
Lasting how long?
_____ mins _____ hrs
☐ Joint pain
☐ Muscle weakness
☐ Muscle tenderness
☐ Joint swelling
List joints affected in the last 6 months:
_____
_____
_____
_____
_____

Integumentary (skin and/or breast)
☐ Easy bruising
☐ Redness
☐ Rash
☐ Hives
☐ Sun sensitivity (sun allergy)
☐ Tightness
☐ Nodules/bumps
☐ Hair loss
☐ Color changes of hands or feet in the cold

Neurological System
☐ Headaches
☐ Dizziness
☐ Fainting
☐ Muscle spasm
☐ Loss of consciousness
☐ Sensitivity or pain of hands and/or feet
☐ Memory loss
☐ Night sweats

Psychiatric
☐ Excessive worries
☐ Anxiety
☐ Easily losing temper
☐ Depression
☐ Agitation
☐ Increased irritability
☐ Difficulty falling asleep
☐ Difficulty saying asleep

Endocrine
☐ Excessive thirst
☐ Loss of muscle strength/mass
☐ Muscle cramps
☐ Dry/coarse skin
☐ Intolerance to cold
☐ Intolerance to heat

Hematologic/Lymphatic
☐ Swollen glands
☐ Tender glands
☐ Anemia
☐ Bleeding tendency
☐ Transfusion/when _____

Allergic/immunologic
☐ Frequent sneezing
☐ Increased susceptibility to infection

Patient Name_____ DOB_____ Date_____

PRIOR TREATMENT

Have you been satisfied with previous medical care? ☐ Yes ☐ No

If no, comment (optional): _____

A: Put a check next to each type of treatment you have had for your back/neck or pain problem in the past.
B: Check the column that best describes the effect of the treatment. If you have had treatments not given on the list, write them in at the bottom and indicate how they affected you.

		Helped	**Made things worse**	**Didn't do much either way**
Stretching Exercises	_____	_____	_____	_____
Hot packs	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____
Ice	_____	_____	_____	_____
Massage	_____	_____	_____	_____
Electrical stimulation	_____	_____	_____	_____
TENS unit for home use	_____	_____	_____	_____
Body mechanics training	_____	_____	_____	_____
Physical Therapy	_____	_____	_____	_____
Strengthening exercises	_____	_____	_____	_____
Aerobics (e.g. exercise bike)	_____	_____	_____	_____
Gravity Inversion	_____	_____	_____	_____
Traction	_____	_____	_____	_____
Bed rest	_____	_____	_____	_____
Chiropractic treatment	_____	_____	_____	_____
Osteopathic Manipulation	_____	_____	_____	_____
Biofeedback	_____	_____	_____	_____
Trigger point injections	_____	_____	_____	_____
Epidural (spinal) injections	_____	_____	_____	_____
Facet joint injections	_____	_____	_____	_____
Soft back brace	_____	_____	_____	_____
Rigid back brace	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Anti-inflammatory medication	_____	_____	_____	_____
Narcotic pain medication	_____	_____	_____	_____
Muscle relaxant medication	_____	_____	_____	_____
Anti-depressant medication	_____	_____	_____	_____
Surgery	_____	_____	_____	_____

Other: _____

Thank you very much for taking the time to fill out this form in its entirety. We understand that it is a very long and detailed form. It does however allow us to better serve your needs.

BEALS INSTITUTE

ARTHRITIS, OSTEOPOROSIS and AUTOIMMUNE DISEASES

Diplomat, American Board of Internal Medicine and Rheumatology, Board Certified

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED MEDICAL INFORMATION

Patient Name (print): _____ Date of Birth ____/____/____

I authorize Beals Institute to discuss medical and/or billing information, and/or provide my personal health information to the following individuals;

Name	Relationship to Patient:	Phone:	☐ Medical ☐ Appointment ☐ Billing/Account
Name	Relationship to Patient:	Phone:	☐ Medical ☐ Appointment ☐ Billing/Account
Name	Relationship to Patient:	Phone:	☐ Medical ☐ Appointment ☐ Billing/Account

My preferred contact is: ☐ **Phone OR** ☐ **FMH Patient Portal**

The office:

☐ ***MAY*** **leave messages about my care on a voicemail at this number:** _____

☐ ***MAY NOT*** **leave messages about my care on a voicemail or answering machine.**

Expirations or termination of authorization – This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Right to revoke or terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to the Beals Institute.

Redisclosure – We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Beals Institute.

_____ _____

Patient Signature Date

4333 W. St. Joe Hwy., Lansing, MI 48917-4297 (517) 321-1525 FAX (517) 321-7059