Rheumatology Associates, PC
I. Cristiana Stanescu, MD John Vischio, MD
223 Addison Road, suite 304
Glastonbury, CT 06033
860-246-4260 opt 2 860-430-9770

Welcome to our practice. We are honored that you have chosen us for your rheumatologic care.

Hours Office

Mon, Tue, Thu, and Fri from 8am — 12pm and 1pm -5pm; Wed from 8am - 12pm.

Telephone and Communications

- Our staff answers the phone from 9:00 am – 11 am and 1:15 pm - 4:00 pm on Mon, Tue, Thu, and Fri, and from 9:00am - 11:30 am on Wed. . After hours, phone service for urgent rheumatologic matters is provided by one of the doctors in our coverage group on a rotating schedule.
- General medical questions, prescription refill requests, test results and other non-urgent matters should be taken care of during regular office hours. These matters can be sent through MyChart.

New Patients

- New patients are required to bring their insurance card(s) and picture ID.
- All new patient paperwork should be received before we can schedule an appointment.
- Please arrive at least 10 minutes prior to the scheduled appointment time.
- If you have been treated by a physician or hospital for the reason you are visiting us, please request that copies of those medical records, x-ray reports, and lab tests be sent to our office PRIOR to your scheduled appointment.

Appointments

- Automated reminder calls are made prior to the appointment.
- We kindly request at least 24 hours advance notice to cancel or reschedule an appointment.
- New patients who miss their appointment without 24 hours' notice will not be allowed to reschedule.
- For existing patients, we understand that there are occasional circumstances that might keep you from the appointment. There is no charge for the first missed appointment without 24-hour cancellation notice.
- Patients who miss two or more appointments without 24 hours cancellation notice will be charged a fee of $75.00 for each missed appointment. Missed appointment fees must be collected prior to scheduling a subsequent appointment.
- Infusion patients who miss an appointment without the required 24 hours' notice will be subject to a $150 fee. • Patients who miss three appointments without 24 hours cancellation notice will unfortunately be dismissed from our practice.
- Patients who have not been seen in three or more years will be considered a new patient again and will need to follow the new patient protocol.

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- Missed appointments without notice are unfair to other patients who are waiting for appointments.
- Prescription refills
- Please contact your pharmacy or mail order pharmacy at least I week in advance to have them electronically send the refill request to us, or to fax the request to (860) 430-9770
- For all refills, if your rheumatologist determines that a follow-up visit is necessary, you may be required to see him/her prior to being issued a refill.

Medical Records

- Should you wish to have a copy of your medical records sent to you or to another provider, please mail or fax a signed letter of request to our office including your name, date of birth, new provider's name, and fax number for where you would like to have your records sent. Please allow 30 business days to process your request.

We look forward to assisting in your healthcare.
The physicians and staff of Rheumatology Associates

Directions to our Addison Road office:

Route 2 East (from Hartford): Take Exit 6, at the end of the ramp go Left onto Hebron Ave. At the 4th traffic light go Left onto Eastern Blvd. Take Eastern Blvd to the end. At the stop sign make a left onto Addison Road. Turn into the 1 st driveway on your left "Offices at Addison Square", we are in the back of the parking lot on the left. Suite 304 (walk in from parking lot)

Route 2 West (towards Hartford): Take Exit 6, at the end of the ramp, Take a Right, then Right again at the traffic light onto Hebron Ave. At the 2nd traffic light go Left onto Eastern Blvd. Take Eastern Blvd to the end. At the stop sign make a left onto Addison Road. Turn into the 1 st driveway on your left "Offices at Addison
Square", we are in the back of the parking lot on the left. Suite 304 (walk in from parking lot)

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Patient Registration Information

Name: _____ DOB:_____SS#: _____

Address:_____

_____

Phone number: _____ (home, cell, work)

Email Address: _____

Gender: ___ M ____ F ____Non Binary ____ Preferer not to answer

Martial Status: _____

Ethnicity: _____

Preferred Language: _____

Referring Physician: _____

PCP: _____

Pharmacy: _____

_____

Insurance Information

Primary Insurance Payor/ID number

Secondary Insurance Payor/ID number

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Permission to Bill: I authorize Rheumatology Associates P.C, to act as my agent in helping obtain payment from my insurance company. I authorize payment directly to my doctor and I permit this form to be used as my "Signature on file" for all my insurance submissions. I authorize release of any information that is required to obtain payment to my doctor. I understand that I AM RESPONSIBLE for payments to Rheumatology Associates P.C., for charges for the above patient regardless of my insurance coverage. I also understand that in the even my insurance company denies payment, I am responsible for the balance in full. I am aware that I am responsible for any copayments and/or deductibles as in specified under my insurance contract.

HIPAA – Notice of Privacy Practice: HIPAA is a federal law developed to provide a standard to protect your health information. The purpose of the Notice of Privacy Practice is to explain how Rheumatology Associates P.C., may use or disclose your healthcare information. The notice explains the rights that you are guaranteed under HIPAA regulations

Though we take great care to protect the integrity and confidentiality of your healthcare information, we are required by HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have been provided access to the notice. If you would like to review this notice, it is available at the front desk.

Permission to Share Medical Information:

Name/Relationship: _____

Phone Number: _____

ePrescribing: Gives our practice information which drugs are covered by insurance, what medications you are already taking or have tried, and allows your doctor to prescribe and renew prescriptions electronically. This will ensure your prescriptions are filled in a timelier manner, reduce errors and prevent adverse drug reactions to help your doctor treat you more efficiently.

By signing, you are aware that Rheumatology Associates P.C., can request and use your prescription medication history for treatment purposes.

Signature: _____ Date: _____

Rheumatology Associates, P.C.

Christopher Scola, MD John Vischio, MD Ioana C Stanescu, MD

Patient History

NAME: _____ Date: ____/____/____
Last First M. I.

DOB: _____ AGE: _____ Sex: ☐ F ☐ M

Height: _____ Weight: _____

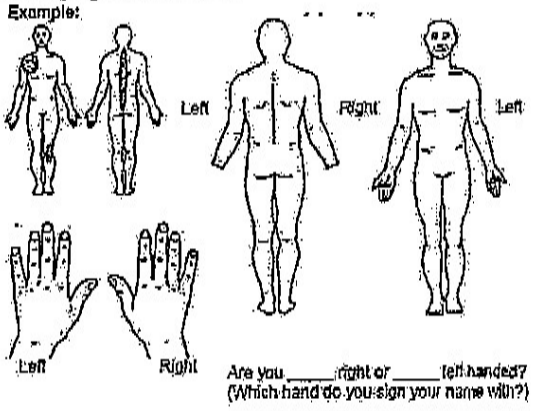
Whom do we thank for referring you here? _____

Name of your primary care physician: _____

Describe briefly your present symptoms: _____

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

Example:



Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

When did your symptoms start? _____

What diagnosis have you been given, if any? _____

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

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

MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? _____

_____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	Dose (include strength and number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

PERSONAL HISTORY

What is your highest educational level? ☐ High school ☐ High School Graduate
☐ Some College Courses ☐ College graduate ☐ Advanced degree

What is your current or past occupation? _____

Are you currently working? ☐ Yes ☐ No If yes, hours/week _____ If not, are you ☐ retired ☐ disabled ☐ sick leave?

Do you receive disability or SSI? ☐ Yes ☐ No If yes, for what disability? _____

What date did this disability begin? _____

With whom do you currently live? _____

How much exercise do you get each week? _____ What kind of exercise? _____

FAMILY HISTORY

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

Number of siblings: _____ Number living _____
Number of children _____ Number living _____ List ages of each _____
Health of children: _____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

	Yourself	Relative		Relationship
1. Arthritis (type unknown)	☐	☐	1	
2. Osteoarthritis	☐	☐	2	
3. Rheumatoid arthritis	☐	☐	3	
4. Gout	☐	☐	4	
5. Lupus or "SLE"	☐	☐	5	
6. Ankylosing spondylitis	☐	☐	6	
7. Childhood arthritis	☐	☐	7	
8. Sjogren's syndrome	☐	☐	8	
9. Osteoporosis	☐	☐	9	
10. Psoriasis/psoriatic arthritis	☐	☐	10	

PAST MEDICAL HISTORY

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

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Cancer (type) _____
- ☐ Leukemia
- ☐ Psoriasis
- ☐ Angina
- ☐ Heart problems
- ☐ Heart murmur
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Epilepsy (seizures)
- ☐ Cataracts
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach or peptic ulcer
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ HIV/AIDS

Other significant illnesses (please list): _____

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 _____

Do you smoke? ☐ Yes ☐ No ☐ In the past - How long ago? _____

Do you drink alcohol? ☐ No ☐ Yes: Usual drink: _____ How much: _____

Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/significant other

Do you use drugs for reasons that are not medical? ☐ No ☐ Yes If yes, please list: _____

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

Date of last eye exam _____ Date of last chest x-ray _____
Date of last bone density test _____
Result of last TB (PPD) test: ☐ Never done ☐ Negative ☐ Positive Date test performed: _____

GENERAL
☐ Recent weight gain; how much____
☐ Recent weight loss; how much____
☐ Fatigue
☐ Weakness
☐ Fever
☐ Night sweats

MUSCLE/JOINTS/BONES
☐ Morning stiffness
Lasting how long ____ Minutes
____ Hours
☐ Joint pain
☐ Muscle weakness
☐ Joint swelling
List joints affected in the last 6 months

_____
_____
_____
_____

EARS
☐ Ringing in ears
☐ Loss of hearing

EYES
☐ Pain
☐ Redness
☐ Loss of vision
☐ Double or blurred vision
☐ Dryness
☐ Feels like something in eye

MOUTH
☐ Sore tongue
☐ Bleeding gums
☐ Sores in mouth
☐ Loss of taste
☐ Dryness
☐ Recent increase in tooth cavities

NOSE
☐ Nosebleeds
☐ Loss of smell

THROAT
☐ Frequent sore throats
☐ Hoarseness
☐ Difficulty in swallowing
☐ Pain in jaw while chewing

NECK
☐ Swollen glands
☐ Tender glands

HEART AND LUNGS
☐ Pain in chest
☐ Irregular heart beat
☐ Sudden changes in heart beat
☐ Shortness of breath
☐ Difficulty in breathing at night
☐ Swollen legs or feet
☐ Cough
☐ Coughing of blood
☐ Wheezing

STOMACH AND INTESTINES
☐ Nausea
☐ Heartburn
☐ Stomach pain relieved by food
☐ Vomiting of blood/"coffee grounds"
☐ Yellow jaundice
☐ Increasing constipation
☐ Persistent diarrhea
☐ Blood in stools
☐ Black stools

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

BLOOD
☐ Anemia
☐ Bleeding tendency

SKIN
☐ Easy bruising
☐ Redness
☐ Rash
☐ Hives
☐ Sun sensitive
☐ Skin tightness
☐ Nodules/bumps
☐ Hair loss
☐ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM
☐ Headaches
☐ Dizziness
☐ Fainting or loss of consciousness
☐ Numbness or tingling in hands/feet
☐ Memory loss
☐ Muscle weakness

PSYCHIATRIC
☐ Depression
☐ Excessive worries
☐ Difficulty falling asleep
☐ Difficulty staying asleep

For women only:
Age when periods began: _____
Number of pregnancies: _____
Number of miscarriages: _____
Have you reached menopause?
☐ No ☐ Yes If yes, at what age: ____
Date of last Pap smear: _____
Date of last mammogram: _____

If you are still having periods:
Are they regular? ☐ Yes ☐ No
How many days apart? _____