Rheumatology and Internal Medicine Associates PC

64-C Concord Street, Wilmington, MA 01887

Phone: (978) 988-9700 Fax: (978) 988-9701

Web: rimamd.com E-Mail: staff@rimamd.com

Sharon A. Stotsky, M.D.
Internal Medicine/Rheumatology

Joanne Blouin, PA-C
Holly Nguyen, PA-C
Amy McCarron, DNP, NP-BC

Dear _____,

Thank you for choosing our office for your **Primary Care**.

Your appointment is on _____, at _____with _____.

Welcome to **Rheumatology and Internal Medicine Associates P.C.** We hope that we can provide you the highest level of care and counseling possible. In order to do so we would like to inform you of some of the policies and procedure of our office prior to your visit.

We are committed to providing you the best care possible. In order to accommodate for your same day sick visits we have three highly qualified mid-level practitioners who work directly under the supervision of Dr. Sharon Stotsky. These practitioners are Joanne Blouin, PA-C, Amy McCarron DNP, and Holly Nguyen PA-C.

Dr. Stotsky is also part of a call group which consists of numerous local doctors who are also part of the Winchester Hospital network. These doctors are available for your care after regular business hours. If you are to be admitted into the hospital we would like to inform you that Dr. Stotsky uses a hospitalist. This means that Dr. Stotsky does not do rounds on her patients; however you will be followed after your discharge by our office to make sure that the admitting problem is resolved and managed accordingly.

If you have an HMO and have chosen Dr. Stotsky to manage your care, then you are part of the **Winchester Hospital Network...** all the specialists we use are also part of the Winchester Hospital network. If necessary, Dr. Stotsky will recommend physicians outside this referring circle. These referrals are sent to an independent reviewer for processing; therefore, **we cannot guarantee same-day referrals,** but will do our best in emergency situations. Please allow us **six (6) business days** for the processing of your in-circle referrals. Your cooperation is greatly appreciated.

Our office is located at 64-C Concord Street in Wilmington. From RT 93, take Exit #39 (Concord Street Exit). Take a right at the end of the ramp. Take your first left onto Fordham Road. Take your second left into our parking lot. We are located in the building on your right all the way at the end. We are located in Suite C.

Enclosed is a Health History form, please fill out both sides. We have also enclosed our registration form, consent form and a medication list. These forms must be filled out and mailed back to our office one week **prior** to your visit, if we do not receive your completed paperwork by the required date your appointment will automatically be cancelled.

Please notify your insurance company that you have chosen Dr. Stotsky as your primary care physician.

Please bring your insurance card(s) and a photo ID to your visit.
Your insurance co-pay is due at the time of your appointment.

The building is handicapped accessible. If you feel you will need assistance with a wheelchair, or will need the use of one once here, please inform our staff when we call to confirm your appointment, or feel free to call and inform us of your needs.

Sincerely,

Rheumatology and Internal Medicine Associates

Rheumatology & Internal Medicine Associates

PLEASE REVIEW, PROVIDE CORRECTED OR MISSING INFORMATON, AND SIGN

PATIENT INFORMATION

Patient:	**Date of Birth:**
Address One:	**Social Security #:**
Address Two:	**Sex:** **Race:**
City:	**Language:**
State: **Zip:**	**Marital Status:**
Home Phone#:	**Employer:**
Work Phone#:	**Occupation:**
Cell Phone#:	**Emergency Contact:**
Spouse:	**Emergency Phone#:**
Spouse Phone#:	**Emergency Relationship:**

OTHER INFORMATION

Drugstore:	**Drugstore Phone**
Primary Care Physician:	**Primary Care Physician Phone#:**

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security#:**
Address Two:	
City:	**Employer:**
State: **Zip:**	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State:** **Zip:**
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Subscriber Name:	**Subscriber Name:**
Subscriber 1 Birthday:	**Subscriber 2 Birthday:**
Workers Comp? (circle 1) Yes No	**If W/Comp give Case# at Check In**

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize my insurance company to pay and hereby assign directly to my physician all benefits, if any, otherwise payable to me for the services as described on the attached forms. I understand I am financially responsible for all charge incurred and am responsible for obtaining a valid referral, if needed. I further acknowledge that my insurance benefits, when received by and paid to my physician to be applied to my account, in accordance with above said assignment. I authorize the release of medical information to my insurer. I also request payment of authorized Medicare/government benefits to be made on my behalf to my physician for any services furnished by that physician.

X_____ _____

Authorized Signature of Subscriber/Patient Date

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Internal Medicine/Rheumatology
Hoai-Nu vo, M.D.
Internal Medicine

Joanne Blouin PA-C
Jennifer Damitsian, NP
Holly Nguyen, PA-C
Amy Mccarron, DNP, NP-BC

CONSENT FORM

Patient Name: Patient #: Date of Birth:

☐ **I GIVE MY PERMISSION** to discuss my medical information with persons listed below, (please do not include physicians):

Name:	Phone:
Name:	Phone:
Name:	Phone:
Name:	Phone:

*This **DOES NOT INCLUDE** any SENSITIVE information, but allows to call regarding appointments, scheduled tests, and to discuss other pertinent information.*

☐ **I DO NOT GIVE MY PERMISSION** for you to speak to anyone regarding my medical information.

The best way to contact me is _____, and I understand that is my responsibility to inform Dr. Stotsky's office if this number or email address changes.

☐ **I GIVE MY PERMISSION** to leave messages on my answering machine.

IF YOUR PHONE DOES NOT ACCEPT BLOCKED NUMBERS, WE WILL BE UNABLE TO REACH YOU.

_____ _____
Signature **Date**

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Patient's Name: _____ Date: _____

MEDICATION LIST

Please list all medications you are currently taking (from ALL physicians you are seeing).
Please include aspirin, vitamins, and/or herbal extracts.

Name of Medication and/or Supplement	*What strength?*	*How often do you take it?*	*What do you take it for?*	*Date Changed*

Dates reviewed and initials

Patient Name: _____ DOB: _____

Dear Patient:

We are required to collect the following information as part of our Electronic Medical Record Implementation and meeting the Federal Guidelines for Meaningful Use Standards.

Please check off the appropriate box and return to the front desk.

Gender: ☐ Male ☐ Female

Race:
- ☐ Asian
- ☐ Black or African American
- ☐ More than 1 Race
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Refused to report/unreported
- ☐ White

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Refused to report/ Unreported

Language:
- ☐ English
- ☐ Spanish
- ☐ Other – Please Specify _____

Place of Birth: _____

Marital Status: _____

Date: _____ Patient Signature: _____

Thank You.

HEALTH HISTORY

(Confidential)

SHARON A. STOTSKY, M.D
64-C Concord Street, Wilmington, Massachusetts 01887
Phone: 978-988-9700 Fax: 978-988-9701 E-mail: staff@rimamd.com

Name: _____ Today's Date: _____

Age: _____ Birthdate: _____ Date of last physical examination: _____

What is the reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other: _____

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other: _____

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononeucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

YOUR PHARMACY	ALLERGIES To medications or substances.
Name:	
City:	
Phone:	

PLEASE TURN OVER TO COMPLETE

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other:	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ No ☐ Yes (please give approximate dates)

SERIOUS ILLNESSES OR INJURIES

Date	Description	Outcome

PREGNANCY HISTORY

Year	Sex	Complications (if any)

HEALTH HABITS

Check (✓) which substances you use and describe how much you use.

	Alcohol	
	Caffeine	
	Drugs	
	Tobacco	
	Other	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed by _____ Date _____