



Colorado Center  
for **Arthritis & Osteoporosis**, LLC

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*BOARD CERTIFIED IN RHEUMATOLOGY*

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*BOARD ELIGIBLE IN RHEUMATOLOGY*

Welcome to Colorado Center for Arthritis & Osteoporosis, LLC. Our commitment to you and to your referring physician is to provide the highest quality, most efficient and caring service possible. Please read and follow the check list below.

We look forward to meeting you.

First Visit Checklist:

- \_\_\_ **1. Bring your completed Patient Health Questionnaire\*.**
- \_\_\_ 2. Bring your insurance card(s).
- \_\_\_ 3. Bring a photo ID.
- \_\_\_ 4. Bring your medical records (if applicable).
- \_\_\_ 5. Be prepared to pay your insurance co-pay.
- \_\_\_ 6. Arrive 10-15 minutes before your scheduled appt. time\*\*.

\*Please remember: you must have your COMPLETED Health Questionnaire with you in order to be seen.

\*\*Please complete packet using blue or black ink ONLY.

**\*\*\*Due to changes related to the Affordable Care Act, we need to collect co-pays and co-insurance at check-in, otherwise we will have to reschedule your appointment.**

**\*\*\*Due to the length and complexity of a new consultation, patients arriving late may need to be rescheduled.**

**LONGMONT**

1715 Iron Horse Drive  
Suite 100  
Longmont, CO 80501

**BOULDER**

1840 Folsom  
Suite 105  
Boulder, CO 80302

**BROOMFIELD**

2095 West 6th Avenue  
Suite 106  
Broomfield, CO 80020

**WHEAT RIDGE**

3555 Lutheran Parkway  
Suite 360  
Wheat Ridge, CO 80033

**PHONE 720.494.4700**

**TOLL FREE 1.877.508.5510**

**FAX 720.494.4706**

**WEBSITE [www.ccao.net](http://www.ccao.net)**

# Colorado Center for Arthritis & Osteoporosis New Patient Information Form

Date of first appointment: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
LAST FIRST M.I.

Address: \_\_\_\_\_ Email: \_\_\_\_\_  
STREET Apt. #  
CITY STATE ZIP

Phone(s): Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Primary Language (circle one): English Spanish Other: \_\_\_\_\_

Race/Ethnicity (circle one): Caucasian Hispanic Asian African American Native American Chinese Filipino Japanese  
Native Hawaiian Pacific Islander Multi-Racial Decline to give/unknown Other: \_\_\_\_\_

Referred by (circle one): Self Family Friend Physician Other health professional

Name of person making referral: \_\_\_\_\_

Name of primary care provider (general or family doctor): \_\_\_\_\_

Do you have an orthopedic surgeon? \_\_\_\_\_ If so, name: \_\_\_\_\_

A referral letter will be sent to your **primary care provider** and to the **physician who referred you** (if any). Please list any other people that you would like to receive a letter below:

Name: \_\_\_\_\_ Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Current symptoms

Briefly describe the symptoms that prompted this visit: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Approximate date when symptoms began: \_\_\_\_\_ Are the symptoms getting **better**, **worse** or **staying the same** (circle one)?

What diagnoses have you been given? \_\_\_\_\_

What treatments (other than medications, which will be listed later) have you received? \_\_\_\_\_

\_\_\_\_\_  
Please list other practitioners that you have seen for this problem: \_\_\_\_\_  
\_\_\_\_\_

## Systems Review (check if you have these symptoms)

### General:

- \_\_\_\_\_ Recent weight gain  
(Intentional? Y / N Amount: \_\_\_\_\_ )  
Over what period? \_\_\_\_\_
- \_\_\_\_\_ Recent weight loss  
(Intentional? Y / N Amount: \_\_\_\_\_ )  
Over what period? \_\_\_\_\_
- \_\_\_\_\_ Fatigue
- \_\_\_\_\_ Fever
- \_\_\_\_\_ Night sweats

### Eyes:

- \_\_\_\_\_ Pain ( L R )
- \_\_\_\_\_ Redness ( L R )
- \_\_\_\_\_ Loss of vision ( L R )
- \_\_\_\_\_ Double vision
- \_\_\_\_\_ Blurred vision
- \_\_\_\_\_ Dryness
- \_\_\_\_\_ Itching eyes

### Ears, Nose and Throat:

- \_\_\_\_\_ Loss of hearing ( L R )
- \_\_\_\_\_ Frequent nosebleeds
- \_\_\_\_\_ Sores in mouth
- \_\_\_\_\_ Dry mouth
- \_\_\_\_\_ Difficulty swallowing

### Lungs:

- \_\_\_\_\_ Shortness of breath
- \_\_\_\_\_ Cough
- \_\_\_\_\_ Coughing up blood
- \_\_\_\_\_ Wheezing
- \_\_\_\_\_ Loud snoring

### Heart:

- \_\_\_\_\_ Chest pains
- \_\_\_\_\_ Irregular heart beat
- \_\_\_\_\_ Fluid retention in legs or feet
- \_\_\_\_\_ Heart murmurs
- \_\_\_\_\_ Fingers or toes turn blue/white in the cold

### Stomach and intestines:

- \_\_\_\_\_ Nausea
- \_\_\_\_\_ Vomiting
- \_\_\_\_\_ Vomiting of blood or coffee ground material
- \_\_\_\_\_ Heartburn
- \_\_\_\_\_ Stomach pains
- \_\_\_\_\_ Diarrhea
- \_\_\_\_\_ Constipation
- \_\_\_\_\_ Blood in stools
- \_\_\_\_\_ Black stools

### Urinary and reproductive:

- \_\_\_\_\_ Pain or burning on urination
- \_\_\_\_\_ Frequent urination
- \_\_\_\_\_ Urination during the night (# of times \_\_\_\_\_ )
- \_\_\_\_\_ Blood in Urine
- \_\_\_\_\_ Genital rashes
- \_\_\_\_\_ Genital ulcers

#### Men only:

- \_\_\_\_\_ Discharge from penis
- \_\_\_\_\_ Difficulty with erections

#### Women only:

- \_\_\_\_\_ Vaginal dryness
- Number of pregnancies \_\_\_\_\_
- Number of miscarriages \_\_\_\_\_
- Age at which periods stopped (menopause): \_\_\_\_\_
- Was menopause **natural** or **surgical** (hysterectomy)? (circle one)
- Have your ovaries been removed?  
**Yes No One removed**

### Blood/Lymph:

- \_\_\_\_\_ Anemia
- \_\_\_\_\_ Low white blood cells
- \_\_\_\_\_ Low platelets
- \_\_\_\_\_ Bleeding tendency
- \_\_\_\_\_ Blood clots

### Nervous System:

- \_\_\_\_\_ Headaches
- \_\_\_\_\_ Dizziness
- \_\_\_\_\_ Fainting/Loss of consciousness
- \_\_\_\_\_ Seizures
- \_\_\_\_\_ Numbness or tingling of hands
- \_\_\_\_\_ Numbness or tingling of feet
- \_\_\_\_\_ Memory loss
- \_\_\_\_\_ Difficulty concentrating
- \_\_\_\_\_ Difficulty with balance/falling
- \_\_\_\_\_ Difficulty falling asleep
- \_\_\_\_\_ Difficulty staying asleep

### Psychiatric:

- \_\_\_\_\_ Depression
- \_\_\_\_\_ Anxiety

### Skin:

- \_\_\_\_\_ Rash
- \_\_\_\_\_ Hives
- \_\_\_\_\_ Sun sensitivity
- \_\_\_\_\_ Sores or ulcers
- \_\_\_\_\_ Hair loss

### Endocrine:

- \_\_\_\_\_ Intolerant of cold
- \_\_\_\_\_ Intolerant of heat

### Allergic/Immunologic:

- \_\_\_\_\_ Hay fever
- \_\_\_\_\_ Recent infection
- \_\_\_\_\_ Frequent infections

### Muscles/Bones /Joints:

- \_\_\_\_\_ Muscle weakness
- \_\_\_\_\_ Muscle pain
- \_\_\_\_\_ Neck Pain
- \_\_\_\_\_ Back Pain
- \_\_\_\_\_ Morning stiffness  
Lasting how long?  
\_\_\_\_\_ Minutes / Hours
- \_\_\_\_\_ Joint pain
- \_\_\_\_\_ Joint swelling
- \_\_\_\_\_ Joint redness

Joints affected in the last 6 months:

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Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
LAST FIRST M.I.

## Personal Medical History (check if you have ever had these conditions)

Arthritic conditions:

Osteoarthritis       Rheumatoid arthritis       Ankylosing spondylitis       Osteoporosis  
 Lupus       Arthritis (unknown type)       Childhood arthritis       Osteopenia  
 Gout       Fibromyalgia

Other conditions:

Epilepsy/seizures       Heart problems       Kidney disease       Tuberculosis  
 Migraine headaches       High blood pressure       Asthma       Diabetes  
 Emphysema       High cholesterol       Cataracts       Rheumatic fever  
 Depression       Stroke       Glaucoma       Underactive thyroid (hypothyroidism)  
 Bipolar disorder       Psoriasis       Stomach ulcers       Overactive thyroid (hyperthyroidism)  
 Cancer       Celiac Disease       Hyperparathyroidism

Type: \_\_\_\_\_

Other significant illness: \_\_\_\_\_

## Surgical History

Type of operation	Year	Reason
_____		
_____		
_____		
_____		
_____		

Any serious injuries/accidents? **Y N** Describe: \_\_\_\_\_

## Health Maintenance

Date of last physical: \_\_\_\_\_ Date of last bone density scan (DXA): \_\_\_\_\_

Date of last eye examination: \_\_\_\_\_ Date of last TB skin test: \_\_\_\_\_ Result: + -

## Bone Health

Have you ever broken a bone? **Y N** If so, when, how and which bone? \_\_\_\_\_

How tall were you at your tallest? \_\_\_\_\_ Have you lost height? **Y N** If so, how much? \_\_\_\_\_

Have you ever taken prednisone or similar steroid for more than a few weeks at a time? **Y N** If so, give details as to when, how much, for what reason and how long? \_\_\_\_\_

Does anyone in your family have osteoporosis? **Y N** If so, who? \_\_\_\_\_

Did anyone in your family break a hip? **Y N** If so, who? \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
LAST FIRST M.I.

## Medications

**Present medications (include vitamins, supplements and over-the-counter medications)**

Name of medication	Strength	Times per day	Date started	How much did it help?		
				A lot	Some	Not at all

### Calcium intake (please make your best guess at average amounts)

Number of glasses of milk per day: \_\_\_\_\_ Number of cups of yogurt per day: \_\_\_\_\_

Number of servings of cheese per day (1 serving = 1 slice = 1 oz.): \_\_\_\_\_

Calcium supplements: Type: \_\_\_\_\_ Milligrams per tablet: \_\_\_\_\_ Number per day: \_\_\_\_\_

## Medication Allergies

Name of medication	Type of Reaction	Date

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
LAST FIRST M.I.

## Habits

Have you ever smoked? \_\_\_\_\_ If so: What year did you start? \_\_\_\_\_ How many packs per day? \_\_\_\_\_

If you have quit smoking, when did you quit? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If so, how many drinks per day? \_\_\_\_\_ Per week? \_\_\_\_\_

Do you use any "street drugs" or any prescription drugs for non-medical reasons? \_\_\_\_\_

If so, which drugs? \_\_\_\_\_ Have you ever used IV drugs? \_\_\_\_\_

Do you exercise regularly? \_\_\_\_\_ If so, describe your exercise routine: \_\_\_\_\_

## Social History

Where were you born: \_\_\_\_\_ Where did you grow up: \_\_\_\_\_

Current Marital status (circle one): **Never married** **Married** **Widowed** **Divorced** **Separated** **Domestic partnership**

Spouse/significant other name: \_\_\_\_\_ Major illnesses of spouse: \_\_\_\_\_

Who else lives in your household: \_\_\_\_\_

Educational level: **Did not finish H.S.** **H.S. Graduate** **Some college**  
**Bachelor's degree** **Master's degree** **Doctoral degree (list type)** \_\_\_\_\_

Occupation: \_\_\_\_\_ Presently employed? \_\_\_\_\_ Number hours per week: \_\_\_\_\_

Does your medical condition interfere with your ability to do your job? \_\_\_\_\_

Do you receive disability income? \_\_\_\_\_ Are you applying for disability? \_\_\_\_\_

## Family History

	If living		If deceased	
	Age	Current Health	Age at death	Cause
Father				
Mother				

Number of brothers \_\_\_\_\_ Number living \_\_\_\_\_ Number of sisters \_\_\_\_\_ Number living \_\_\_\_\_

Serious illnesses in siblings \_\_\_\_\_

Number of children \_\_\_\_\_ Number living \_\_\_\_\_ Ages: \_\_\_\_\_

Serious illnesses in children \_\_\_\_\_

Do you know of any blood relative who has had (**give relationship**): Cancer (list type) \_\_\_\_\_

Rheumatoid arthritis \_\_\_\_\_ Fibromyalgia \_\_\_\_\_ Stroke \_\_\_\_\_

Ankylosing spondylitis \_\_\_\_\_ Lupus \_\_\_\_\_ Asthma \_\_\_\_\_

Osteoarthritis \_\_\_\_\_ Osteoporosis \_\_\_\_\_ Bleeding tendency \_\_\_\_\_

Gout \_\_\_\_\_ Heart problems \_\_\_\_\_ Alcoholism \_\_\_\_\_

Childhood arthritis \_\_\_\_\_ High blood pressure \_\_\_\_\_ Psoriasis \_\_\_\_\_

Arthritis (unknown type) \_\_\_\_\_ Depression \_\_\_\_\_ Diabetes \_\_\_\_\_



Colorado Center  
for Arthritis & Osteoporosis, LLC

## Acknowledgment of Notice of Privacy Practices

\_\_\_\_\_  
Name of Patient (please print)

\_\_\_\_\_  
Date of Birth

I hereby acknowledge that I received Colorado Center for Arthritis & Osteoporosis, LLC's Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient or Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Legal Guardian  
(If patient is under 18)

\_\_\_\_\_  
Date



## Financial Policy

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Thank you for choosing us as your provider for your rheumatology needs. Our commitment to you and to your referring physician is to provide the highest quality, most efficient and caring service possible.

The following policy is provided to clarify financial responsibility for you and your insurer for services you receive from our practice, and to be certain that we follow applicable laws. Please read entirely, ask any questions that you may have, and sign in the space provided. A copy will be provided upon request.

Your insurance carrier defines your eligibility and benefits. CCAO will bill your primary and secondary (if applicable) insurance carrier for services provided. If you have a copayment, coinsurance and/or deductible, you are required to pay those amounts, as they are your responsibility.

### **Payments due at time of service (upon check-in):**

Consult - we will determine an estimated cost (applied to copayment/coinsurance/deductible) according to your insurance plan. In the occasion of under or over payment, you will either receive a statement with the remaining balance or a refund check.

Copayment – due at every visit

Self-pay – we will calculate the amount owed for your visit

Current balances – if you have an unpaid balance, you will need to pay this during check in

Non-contracted insurance (out of network): If CCAO does not have a contract with your health insurance carrier, you will be responsible for all charges not covered under your health insurance plan.

Once CCAO has received the processed claim/payment from your insurance, a statement with the remaining charges for both covered and non-covered services will be sent to you by mail. Payment is expected in full within 30 days of receipt of statement. Unless CCAO approves other arrangements, payments not received within 30 days will be assessed a \$20.00 rebilling fee for every 30 days not paid and is subject to collections.

Your signature below confirms that you have read the above policy and accept financial responsibility for services rendered by Colorado Center for Arthritis and Osteoporosis. **This document cannot be altered.**

### SELECT ONE:

CCAO may bill my insurance directly and my insurance may pay CCAO directly for medical services.

I decline to assign my insurance benefits to CCAO. I am aware that I will be responsible for payment at the time of service and for collecting any benefits from my insurance.

Patient Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_

(Parent or Legal Guardian if under 18 years old)





**COLORADO CENTER FOR ARTHRITIS AND OSTEOPOROSIS, LLC**

**RELEASE OF MEDICAL AND BILLING INFORMATION TO PERSONAL CONTACTS**

PATIENT NAME: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

*Under federal law, a patient's protected health information cannot be shared with other people, even family members, without explicit permission from the patient. This means that if a family member or other individual calls us to discuss any aspect of your medical care, such as test results or a message from your doctor, we cannot discuss this with them without your explicit permission. If you wish to grant us permission to discuss your medical or billing information with a family member or other trusted individual, please complete and sign this form. Also, if you are comfortable with us leaving this information on your voice mail, please indicate below. If you wish to revoke this permission at any time, you must do so in writing.*

PERMISSION TO DISCUSS MEDICAL AND BILLING INFORMATION WITH OTHERS

I give permission to CCAO to discuss my medical and/or financial information with the following personal contacts:

Name	Phone	Relationship to you	Medical	Financial
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

**-OR-**

I DO NOT give permission to CCAO to discuss my medical and financial information with any personal contacts.

PERMISSION TO LEAVE MEDICAL INFORMATION ON VOICE MAIL

I give my permission for CCAO Staff to leave medically privileged information on the following voicemail:

Voice mail number: \_\_\_\_\_

**-OR-**

I DO NOT give permission for CCAO Staff to leave medically privileged information on voicemail.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian Signature  
(If patient is under 18)

\_\_\_\_\_  
Date

## **Discrimination is Against the Law**

Colorado Center for Arthritis and Osteoporosis complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Colorado Center for Arthritis and Osteoporosis does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Colorado Center for Arthritis and Osteoporosis:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact **Jess Houwen**

If you believe that Colorado Center for Arthritis and Osteoporosis has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Jess Houwen, Civil Rights Coordinator, 1715 Iron Horse Dr, Ste 100; Longmont, CO 80501, Phone: 720-494-4700, Fax: 720-494-4706, [office@ccao.net](mailto:office@ccao.net). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Jess Houwen, Civil Rights Coordinator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Appendix B to Part 92—Taglines Informing Individuals With Limited English Proficiency of Language Assistance Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 303-485-5200.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 303-485-5200.

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 303-485-5200。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 303-485-5200 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 303-485-5200.

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 303-485-5200.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 303-485-5200.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 303-485-5200.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 303-485-5200.

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्त भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 303-485-5200 ।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 303-485-5200.

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。303-485-5200まで、お電話にてご連絡ください。

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 303-485-5200.

با.باشد یم فراهم شما یرا بگانی بصورت یر زبان لاتیتسه،دیکن یم گفتگو یرفارس زبان به اگر: توجه  
303-485-5200 یر یرگ تماس

Dè dɛ nìà kɛ dyédé gbo: ɔ jũ ké m̀ [Bàsòò-wùdù-po-nyò] jũ ní, nìí, à wuɖu kà kò dọ̀ po-poò béin m̀ gbo kpáa.  
Đá 303-485-5200

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 303-485-5200.

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 303-485-5200