ILEANA ANTONIADIS, M.D., F.A.R.A.

BOARD CERTIFIED IN
INTERNAL MEDICINE & RHEUMATOLOGY

207 ROUTE 71
SPRING LAKE HEIGHTS, N.J. 07762

TELEPHONE 732-359-7232
FAX 732-359-7233

Dear Patient:

Welcome to Dr. Ileana Antoniadis M.D. F.A.R.A Arthritis and Rheumatic Diseases of Spring Lake Heights. We value your confidence in our ability to address your health care needs.

This is to confirm your initial appointment on _____ at _____ with Doctor_____.

Our office is located at 207 Route 71, Spring Lake Heights NJ 07762. Cross road is Ocean Rd.

Dr. Ileana Antoniadis provides interpretive services when advance notice is given. If you need to change or cancel an appointment please call 732-359-7232. We request that you notify us of your change or cancellation no less than 24 hours in advance. A timely notification will permit patients that are waiting to schedule a sooner appointment.

We want your visit with us to be a success. We have included a checklist to help you prepare for our time together. It is very important that you complete the attached forms, and bring them with you to your appointment. This will reduce your registration time on the day of your visit and provide your doctor with important information needed to provide you with the highest quality of care.

Thank you for choosing us. We look forward to seeing you and participating in your care.

Sincerely,

Dr. Ileana Antoniadis Staff

Tel: 732-359-7232
Fax: 732-359-7233
http://iantoniadismd.com

Dr. Antoniadis **New Patient Checklist**

Prior to your visit:

__Fax Copies of medical records or bring them with you at the time of your visit. This includes pertinent physician progress notes, most recent blood test, pertinent x-ray, recent BMD, or any other test that might be helpful to your doctor in evaluating your arthritic condition. Please fax them to (732) 359-7233. If unable to access fax machines please bring records with you to your visit.

Please bring these items to your visit:

___ Completed/signed forms in this welcome packet.

___ Copies of Medical Records and MRI/CT films or reports if not faxed or mailed.

___ A list of current medications, including names, doses, and frequency.

___ Name and address of any physicians.

___ Please bring your current Insurance card(s) and photo ID to each visit.

___ Co-Pays/Deductibles will be collected upon check in at each visit. This includes Commercial Insurance, Medicare, (Please look on your insurance card for amount) we accept cash or check only.

___ If you will not be using insurance, please be prepared to pay the full fee for services.

___ Make sure you provide the physician with your COMPLETE health history. Make sure to note all of your medication, vitamins, and supplements on medication list. Be honest with your health history and don't withhold information. The physician needs to know your entire previous healthcare conditions in order to evaluate your current concerns.

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PATIENT INFORMATION – ***PLEASE PRINT***

DATE OF APPOINTMENT: _____

NAME: _____ HOME PHONE #: _____
ADDRESS: _____ CELL PHONE #: _____
CITY: _____ STATE: _____ ZIP CODE: _____ EMAIL: _____
SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ AGE: _____ SEX: Male or Female
SEXUAL ORIENTATION (circle one): Heterosexual or Homosexual or Bisexual GENDER IDENTITY: Male or Female
MARITAL STATUS (circle one): S M W D SPOUSE'S NAME (if applicable): _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE#: _____

PRIMARY CARE PHYSICIAN: _____ CITY/STATE: _____ PHONE #: _____

Please List **ALL** other Physicians/Specialist you are seeing:

Name	**Specialty**	**Phone Number (if known)**

WERE YOU REFERRED BY ANOTHER HEALTH CARE PROFESSIONAL? YES OR NO
IF YES, NAME AND PHONE # (if known): _____

ALLERGIES/Including: Medications, Seasonal, Latex, Etc... (CIRCLE ONE): YES OR NO
IF YES, NAME OF ALLERGEN: _____ REACTION: _____
_____ REACTION: _____
_____ REACTION: _____
_____ REACTION: _____

LOCAL PHARMACY: _____ CITY/STATE: _____ PHONE #: _____
MAIL-AWAY PHARMACY (if applicable): _____

PRIMARY INSURANCE COMPANY: _____
ID #: _____ GROUP #: _____
SECONDARY INSURANCE COMPANY: _____
ID#: _____ GROUP #: _____
PRESCRIPTION COVERAGE: NAME OF COMPANY (copy of card needed): _____

(OVER →)

ILEANA ANTONIADIS M.D.

Insurance Agreement

PATIENTS WITH MEDICARE/ MEDICARE ADVANTAGE PPO

I authorize treatment and give permission to Dr. Antoniadis and any of her authorized representatives to use my signature to electronically submit charges to Medicare/ Medicare Advantage for reimbursement of the services provided.

I agree to pay all charges associated with the said treatment if **not** covered by Medicare and my secondary insurance (IE; Deductible, Co-Pay, Etc...)

A COPY OF THIS SIGNATURE IS VALID AS THE ORIGINAL.

Signature	Relationship to Patient	Date

PATIENTS WITH COMMERCIAL INSURANCE ONLY

Dr. Antoniadis is **NOT** participating with any commercial insurance, **Medicaid** or **Medicare Advantage HMO** plans at this time.

I Authorize treatment and agree to pay all charges associated with said treatment for services rendered at the time of examination.

A receipt will be given to me to submit to my insurance company for reimbursement.

I understand that I may protest any charges on these statements in writing within 30 days of the billing date.

I understand that I am finically responsible for any balance on my account and in the event that my account is placed with a collection agency, I will pay collection fees (33.5% of balance) and all court costs incurred by Dr. Antoniadis in addition to my balance.

A COPY OF THIS SIGNATURE IS VALID AS THE ORIGINAL.

Signature	Relationship to Patient	Date

ILEANA ANTONIADIS M.D.

Initial Evaluation Form/ Patient History

Present/Past Occupation: _____ **Job Title:** _____

Are you: RETIRED (circle one): **YES** OR **NO** **DISABLED** (circle one): **YES** OR **NO**

Do you have children? (circle one) YES or NO **IF YES,** please provide # of children: _____

NATIVE INFORMATION (please circle):

RACE: White, African American, Asian, Other: _____

ETHNICITY: Hispanic, Latino, Greek, Irish, Italian, Other: _____

RELIGION: Christianity, Judaism, Hinduism, Islam, Buddhism, Other: _____

FAMILY MEDICAL HISTORY: (if applicable) (if known)

FATHER: Known Illnesses: _____ Age at Death: _____ Cause of Death: _____

MOTHER: Known Illnesses: _____ Age at Death: _____ Cause of Death: _____

BROTHER: Known Illnesses: _____ Age at Death: _____ Cause of Death: _____

SISTER: Known Illnesses: _____ Age at Death: _____ Cause of Death: _____

CHILDREN: Known Illnesses: _____ Age at Death: _____ Cause of Death: _____

GRANDPARENT(S): Known Illnesses: _____ Age at Death: _____ Cause of Death: _____

SOCIAL HISTORY (please circle one):

Do you currently smoke? YES or NO **IF YES;** the # of year's: _____ /number of pack(s) per day: _____

Did you ever smoke? YES or NO **IF YES;** how long ago did you quit? _____

Do you drink alcohol? YES or NO **IF YES;** number of drinks per day: _____

Do you drink (circle) COFFEE or TEA? **IF YES;** number of cups per day: _____

PAST AND CURRENT MEDICAL ILLNESSES (please circle ALL that apply):

High Blood Pressure	Osteoporosis/ Osteopenia	Diabetes
Stroke/ TIA	Thyroid Disease	TB or Positive PPD result
High Cholesterol	Coronary Artery Disease/ A-Fib	GOUT
Arthritis/ Stenosis	Cancer(s) specify type/year diagnosed: _____	

OTHER CONDITIONS: _____

_____

ALL PAST SURGERIES: Please list PROCEDURE and DATE (if known):

Procedure	Date	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ILEANA ANTONIADIS M.D.

Initial Office Visit / New Patient Medication list

PLEASE LIST ALL MEDICATIONS, VITAMINS, SUPPLEMENTS YOU ARE CURRENTLY TAKING:

Name	Dose	Frequency

We ask that you please bring an up-to-date medication list to every office visit for review by Dr. Antoniadis.

ILEANA ANTONIADIS M.D.

New Patient/Initial Evaluation – Review Of System

Patient Name: _____ **Date of appointment:** _____

REASON FOR TODAY'S VISIT

Chief Complaint: **(Describe symptoms including: Location, Severity, Associated Symptoms, Duration, Etc...)**

_____

_____

_____

_____

Please Circle 'YES OR NO' For Each Section:

Constitutional Symptoms		
Recent Weight Changes	Loss	Gain
Fever or Chills	No	Yes
Fatigue	No	Yes

Ears/Nose/Mouth/Throat		
Hearing loss	No	Yes
Mouth Sores or Oral Dryness	No	Yes
Swollen Glands	No	Yes
Dry Eyes	No	Yes

Cardiovascular		
Palpitations	No	Yes
Swelling of Feet, Ankles or Hands	No	Yes

Respiratory		
Chronic or Frequent Cough	No	Yes
Shortness of Breath	No	Yes

Gastrointestinal		
Loss of Appetite	No	Yes
Nausea or Vomiting	No	Yes
Frequent Diarrhea	No	Yes
Abdominal Pain or Heartburn	No	Yes

Genitourinary		
Frequent Urination	No	Yes
Burning or Painful Urination	No	Yes
Blood In Urine	No	Yes
Kidney Disease	No	Yes

Musculoskeletal		
Joint Pain	No	Yes
Joint Stiffness or Swelling	No	Yes
Weakness	No	Yes
Muscle Pain or Cramps	No	Yes
Cold Extremities/Raynaud's	No	Yes
Difficulty Walking	No	Yes

Skin		
Rash or Itching	No	Yes
Changes In Skin Color or Texture	No	Yes
Varicose Veins	No	Yes

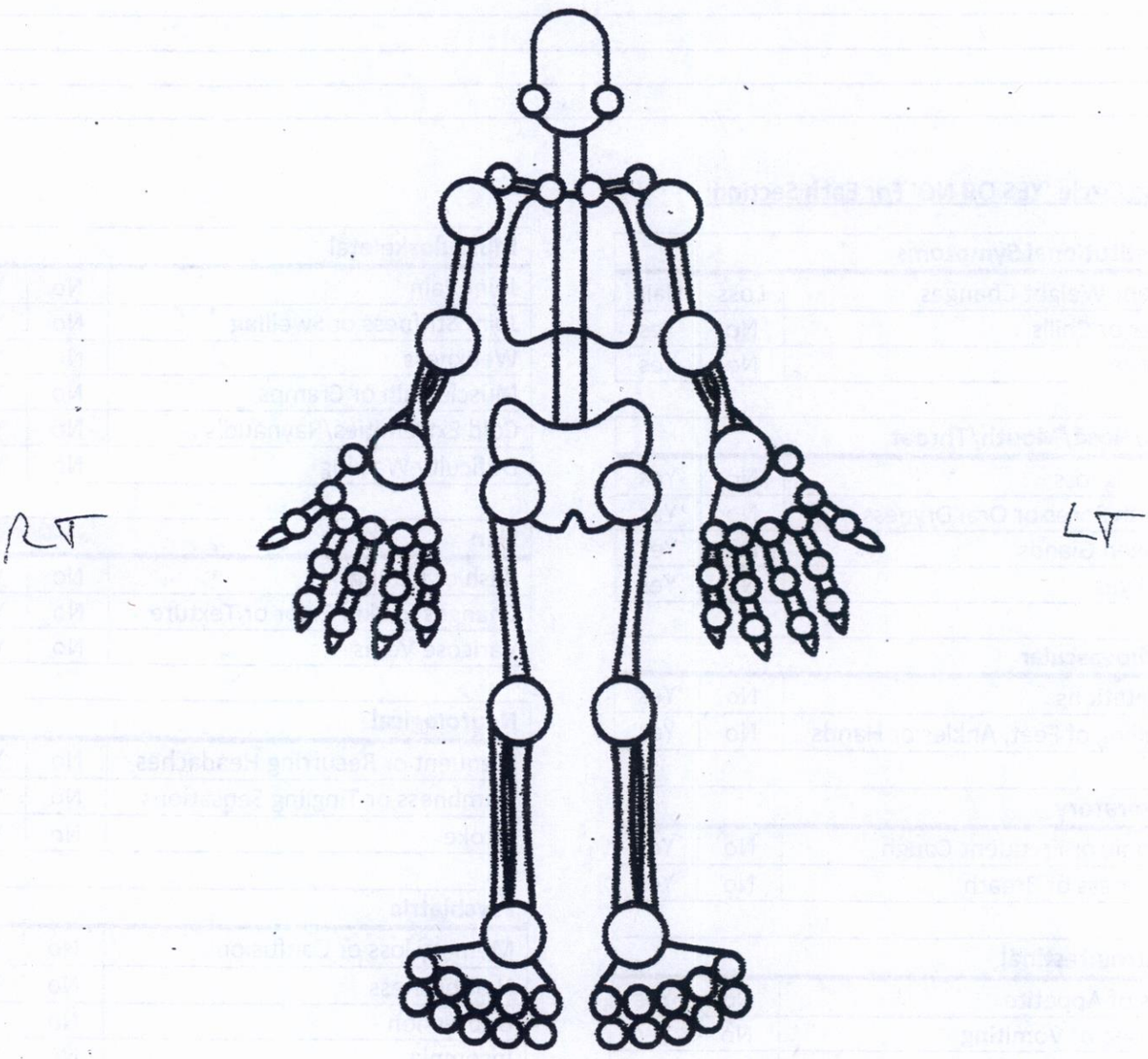
Neurological		
Frequent or Recurring Headaches	No	Yes
Numbness or Tingling Sensations	No	Yes
Stroke	No	Yes

Psychiatric		
Memory loss or Confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

Endocrine		
Excessive Thirst or Urination	No	Yes

Hematologic/Lymphatic		
Bleeding or Bruising Tendency	No	Yes
Anemia	No	Yes

FOR DOCTOR USE



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Patient Acknowledgement and Consent for Use and Disclosures of Protected Health Information (HIPAA)

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have rights to privacy regarding my protected health information: this information will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as appointment reminders, quality assessments, etc.

I acknowledge I have read and understand the displayed Notice of Privacy Practices (HIPAA) containing a more complete description of the uses and disclosures of my health information.

I understand that I may request in writing to amend restrictions on who has access to my personal health information (i.e. spouse) and if any limitations are requested I will notify the office immediately.

Are there any restrictions on who has access to your medical records? YES or NO
Please explain:

_____

_____

Patient Name: _____ **Date:** _____

Relationship to Patient: _____

Signature: _____

A copy of the notice of Privacy Practices (HIPAA) will be provided to me, if requested.

http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/Downloads/HIPAALaw.pdf

(OVER →)

ILEANA ANTONIADIS M.D.

Patient Consents

Patient Consent for Medication History Reconciliation

I _____, **agree** to allow Dr. Antoniadis and her staff to obtain any medication history through our Electronic Health Record system if available. Dr. Antoniadis will be allowed to view and import my current and/or previous medications that were prescribed to me by other physicians.

YES - OR - NO

(Please Circle One)

Signature: _____ Date: _____

Patient Consent for Medically Necessary Procedures

I _____, **agree** to allow Dr. Antoniadis and/or her staff to perform medically necessary procedures as treatment or diagnosis, if needed. These procedures may include joint/tendon sheath injections and aspirations along with IV set up and venipuncture.

If you <u>do not agree</u> with this statement please check this box: ☐

Signature: _____ Date: _____