BooneHealth

Paula McMurtry, MD
Boone Health Rheumatology- Nifong
900 W Nifong Ste 101
Columbia, MO 65203
573-815-6633

Dear _____

Welcome to Boone Health Rheumatology We look forward to seeing you for your scheduled appointment.

_____ at _____

Please arrive 30 minutes early to your appointment You will need to arrive at _____.

1) Please complete the enclosed paperwork and bring it with you to your appointment Do not mail or e-mail it back to us You must arrive 30 minutes early to process your check-in as a first-time patient Failure to arrive early could result in the need to reschedule your appointment.

2) Bring your insurance card and photo ID and the enclosed paperwork completed

3) Any copay or coinsurance is due at the time of service We accept cash, check, Mastercard, Visa and Discover card.

4) If you do not plan to keep this appointment, please contact the office at 573-815-6633 to cancel or reschedule

We look forward to meeting you. Please call our office at 573-815-6633 with any questions or concerns

Sincerely,

Boone Health Rheumatology

Paula J McMurtry, MD

Adult Rheumatology

Patient History Form

Last Name _____ First Name _____ MI_____ Maiden _____

Birthdate _____/_____/_____ Age_____ Birthplace _____ ☐ Male ☐ Female
Month Day Year

Address _____
Street Apt # City State Zip Code

Home Phone _____ Cell Phone _____ Work Phone _____

MARITAL STATUS ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐Widowed

Spouse/SO ☐ Alive/Age_____ ☐ Deceased/Age_____ Major illnesses _____

EDUCATION (circle highest level attended)

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

Occupation _____ Number of hrs worked/Average per week _____

Primary care physician _____ Diagnosis _____

Briefly describe your present symptoms _____

_____Date symptoms began (approximate) _____

Previous treatment for this problem

_____ _____

_____

_____

Please list other practitioners you have seen for this problem

_____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Condition	Yourself	Relative Relationship	Condition	Yourself	Relative Relationship
Arthritis (unknown type)			Lupus or SLE		
Osteoarthritis			Rheumatoid Arthritis		
Gout			Ankylosing Spondylitis		
Childhood Arthritis			Osteoporosis		

Other arthritis conditions _____

Patient Name _____ Date _____ Physician Initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages? ☐ Yes ☐ No How many cups/glasses per day?_____

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

Do you drink alcohol? ☐ Yes ☐ No Number per week? _____

Have you ever been told to cut down on your drinking of alcohol? ☐ Yes ☐No

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

Do you exercise regularly? ☐ Yes ☐ No Type of Exercise? _____Amount per week _____

How many hours sleep do you get at night? _____ Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you now, or have you ever had (check if yes) ☐Cancer ☐Heart problems ☐Asthma ☐Goiter ☐Leukemia

☐Stroke ☐Cataracts ☐Diabetes ☐Epilepsy ☐Nervous breakdown ☐Stomach ulcers ☐Rheumatic fever

☐Bad headaches ☐Jaundice ☐Colitis ☐kidney disease ☐Pneumonia ☐Psoriasis ☐Anemia ☐HIV/AIDS

☐High Blood Pressure ☐Emphysema ☐Glaucoma ☐Tuberculosis

Please list any other significant illness _____

Natural or Alternative Therapies (chiropractic, magnets, massage, over the counter preparations, ect)

_____

_____

Previous Operations

Type	Year	Reason

Any previous fractures? ☐Yes ☐No If yes, please describe_____

Any other serious injuries? ☐Yes ☐No If yes, please describe_____

FAMILY HISTORY

If Living		If Deceased	
Age	Health	Age at Death	Cause
Father			
Mother			

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of children _____

Health condition of children _____

Do you know of any blood relative who has or had (check and give relationship)

☐Cancer _____ ☐heart disease _____ ☐Rheumatic fever _____

☐Tuberculosis _____ ☐Leukemia _____ ☐High blood pressure_____

☐Epilepsy_____ ☐Diabetes _____ ☐Stroke _____ ☐Bleeding tendency _____

☐Asthma _____ ☐Gout _____ ☐Colitis _____

☐Alcoholism _____ ☐Psoriasis _____

MEDICATIONS

Drug Allergies ☐No ☐Yes If yes, please list drug and type of reaction_____

_____

_____

PRESENT MEDICATIONS (List all medications you take including vitamins supplements laxatives and prescriptions)

Name of Drug	Dose {strength (mgs) and number of pills per day}	How long have you taken this medication	Does it help? Please check		
			A lot	Some	None
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

Drug name/Dosage	Length of Time Taken	Please check: Helped? A Lot	Some	Not at All	Reactions
Non-Steroidal Anti Inflammatory Drugs (NSAIDs) Circle any you have taken in the past					
Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsafate) Doloboid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tofmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Codeine (Vicodin, Tylenol 3)					
Propoxyphene (Darvon/Darvocet)					
Disease Modifying Antirheumatic Drugs					
Auranofin, gold pills (Ridaura)					
Gold shots (Myochrysine or Solganol)					
Hydroxychloroquine (Plaquenil)					
Penicillamine (Cuprimine or Depen)					
Methotrexate (Rheumatrex)					
Azathioprine (Imuran)					
Sufasalazine (Azulfidine)					
Quinacrine (Atabrine)					
Cyclophosphamide (Cytoxan)					
Cyclosporine A (Sandimmune or Neoral)					
Elanercept (Enbrel)					
Infliximab (Remicade)					
Osteoporosis Medications					
Estrogen (Premarin etc)					
Alendronate (Fosamax)					
Etidronate (Didronell)					
Raloxifene (Evista)					
Fluoride					
Calcitonin Injection or Nasal (Miacalcin Calcimar)					
Risedronate (Actonel)					

Drug name/Dosage	Length of Time Taken	Please check: Helped?			Reactions
		A Lot	Some	Not at All	
Gout Medications					
Probenecid (Benemid)					
Colchicine					
Allopurinol (Zyloprim/Lopurin)					
Febuxostat (Uloric)					
Others					
Cortisone/Prednisone					
Hyalgan/Synvisc Injections					
Herbal or Nutritional Supplements					
Please list supplements					

BooneHealth
MEDICAL GROUP

Please list previous primary care physician(s) and any specialist(s) you are currently seeing and/or have seen in the recent past. If we need to obtain records from these providers, we will provide an authorization form during your office visit.

Physician First and Last Name | Practice Name and/or City, State

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Physician First and Last Name | Practice Name and/or City, State

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Physician First and Last Name | Practice Name and/or City, State

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Physician First and Last Name | Practice Name and/or City, State

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Patient Name: Patient DOB:
Today's Date:

BooneHealth
1600 E. Broadway, Columbia, MO 65201
573.815.8000 • www.boone.health

Patient Name:_____
Med Rec Number:_____ Acct Number:_____
Age:_____ Gender:_____ DOB:_____ Svc Date:_____

Acknowledgement to Share Information with a Health Information Exchange

CH Allied Services, Inc. dba Boone Hospital Center, Boone Hospital Center's Visiting Nurses, Inc. dba Boone Home Care and Hospice, Boone Physician Services, LLC dba Boone Medical Group and CHAS Physician Services, LLC (collectively referred to herein as "Boone") participates in a Health Information Exchange (HIE). The HIE that Boone Health participates in is a nonprofit, community health information exchange (HIE) that facilitates electronic exchange of patient health information with physicians, hospitals, labs, pharmacies and other providers. This HIE will also connect to other HIEs to allow information to be available to other providers when patients travel outside of our region. Sharing patient information with other providers through an HIE helps Boone save patients' time and make better treatment decisions with a more complete record. It will allow them to avoid duplicate tests and procedures and gain immediate access in emergencies to critical information like allergies, diagnosis, medications and other important data. See Boone's HIE factsheet for more information about how the HIE helps us promote patient health and protects patient information. Patients can also read more about the HIE Boone participates in at **https://boone.health/patients-visitors/**

By initialing below, I understand that Boone shares patient information through the HIE and have received a copy of the HIE's factsheet. The HIE makes every effort to ensure that sensitive patient information, such as HIV/AIDS, mental health, and substance abuse treatment related information (sensitive) information, is blocked from viewing. However, due to system limitations, Boone and the HIE are limited in blocking sensitive information at this time.

_____
Patient Initial

Acknowledgement to Opt-out of Sharing Information with a Health Information Exchange

I understand that I have the right to Opt-Out of having my patient information shared through the HIE. Unless I opt-out, any authorized provider, health plan or other entity that participates in the Health Information Exchange or is a member of a health information exchange that is connected to the HIE Boone participates in, can electronically access and share my health information through the HIE.

Boone will not discriminate against you if you choose to sign an Opt-Out Form and Boone does not require you to share information through the HIE in order to receive medical treatment.

By signing below, I opt-out of sharing my patient information with the HIE.

_____ _____
Patient Signature **Date**

If under 18 years, signature of Parent or Guardian

_____ _____ _____
Legal Representative Name **Date** **Relationship**

_____
Phone Number

BooneHealth
1600 E. Broadway, Columbia, MO 65201
573.815.8000 • www.boone.health

Patient Name:_____

Med Rec Number:_____ Acct Number:_____

Age:_____ Gender:_____ DOB:_____ Svc Date:_____

Consent to Treatment, Authorization of Benefits and Financial Responsibility

Consent to Treatment:

I know that I have the right to make decisions about my/my child's medical treatment. I consent to have the physicians and other health care workers at CH Allied Services, Inc. dba Boone Hospital Center, Boone Hospital Center's Visiting Nurses, Inc. dba Boone Home Care and Hospice, Boone Physician Services, LLC dba Boone Medical Group and CHAS Physician Services, LLC (collectively referred to herein as "Boone") provide medical treatment to me/my child. I understand the medical treatment is provided by physicians and health care workers who may be employees of Boone and other individuals allowed to provide care at Boone.

I consent to having photographs, videos, and other electronic images of me/my child taken and stored for treatment and education purposes. I understand that reasonable efforts will be made to protect the identity of me/my child.

Assignment of Benefits and Financial Responsibility:

I agree that the information I gave to apply for payment is correct for any third-party payers, including Medicare or Medicaid. I have been given a paper listing my rights as a Medicare or Medicaid patient. I know I can ask for a review of my/my child's record to find out about payment or charges I may owe if Medicare or Medicaid will not cover my charges.

If I receive Medicare, Medicaid or other insurance benefits, I know I am responsible to know what my insurance covers and that I can call my insurance plan if I have questions. I also understand I am responsible for any deductibles, co-insurance, and any non-covered charges. I know that I may receive separate bills for services provided by healthcare workers who are not employed by Boone who are authorized to provide care at Boone.

I authorize direct payment to Boone of all insurance benefits. I understand that I am responsible, subject to Boone's Financial Assistance Policy, to pay for portions of my/my child's bill not covered by insurance.

I also agree that I have received or have access to signs and/or brochures which contain information about:

- Advance Directives: What are they? Where can I get one? Do we need one?
- Privacy of my health care information and who may have access to my information
- How the hospital handles personal property (Hospital patients)
- I have been given the information regarding my right of choice in obtaining home care services (Home Care patients)
- Visiting/Office hours, Visitor/Office Policies and Behavior Rules
- The rights and responsibilities I/we have as a patient or family member and who to contact if I have questions

I have read this whole form, or had it read and explained to me, and I had the opportunity to ask questions.

_____ _____

Signature of Person Consenting to Treatment | Relationship to Patient

_____

Signature of Guarantor (if different than above)

THIS IS A PERMANENT PART OF THE MEDICAL RECORD.

FORM ID

BooneHealth

Patient Name:
Med Rec Number: Acct Number:
Age: Gender: DOB: Svc Date:

CONSENT TO RECEIVE AUTOMATED COMMUNICATIONS (E-MAIL, PHONE CALL, AND/OR TEXT MESSAGE)

By signing below, I hereby authorize CH Allied Services, Inc. dba Boone Hospital Center, Boone Hospital Center's Visiting Nurses, Inc. dba Boone Home Care and Hospice, Boone Physician Services, LLC dba Boone Medical Group and CHAS Physician Services, LLC, its service providers and affiliates (collectively referred to herein as "Boone"), to communicate with me via e-mail, phone call, and/or text message at the e-mail address and/or phone number provided below, including through auto-dialed, auto-generated and/or pre-recorded messages. I understand that such e-mails, calls, and/or text messages may include, without limitation, reminders about my upcoming appointments or rescheduling missed appointments, billing or payment information, or telemarketing (e.g., information about Boone's services or products). I understand that notifications may use an autodialer and/or prerecorded or artificial voice and may be repeated multiple times per appointment and may exceed contacts more than three times per week. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, notification of a pending or missed appointment.

I understand that my consent to communicate via e-mail, call, and/or text message is not a condition of my obtaining services from Boone.

I understand that communications sent via unencrypted e-mail or text message over an open network are inherently unsecure, and there is no assurance of confidentiality of information communicated in this manner. Nevertheless, I want Boone to communicate with me via e-mail, phone call, and/or text message as provided below:

I certify I am the user and/or subscriber of the e-mail address and/or phone number provided below, and I accept full responsibility for e-mails, phone calls, and/or text messages made or sent to or from this e-mail address or phone number.

I understand that e-mails and text messages have inherent privacy risks, especially when access to my computer or phone is not password protected or access is provided by my employer.

I understand there may be a delay when responding to e-mails and text message; therefore, if I have an urgent situation, I should not rely on e-mail or text message to request assistance, but should instead seek assistance by means consistent with my needs (e.g., by contacting my primary care provider or calling 911).

I understand that, in order to process and/or respond to my e-mails and/or text messages, individuals at Boone other than those directly involved in my care may need to read my e-mail and/or text messages and that any e-mail or text message and response thereto may become part of my medical record, as appropriate.

I agree to hold Boone harmless from any and all claims and liabilities arising from or related to e-mails, phone calls, or text messages made or sent to or from the e-mail address or phone number provided below.

I agree to notify Boone in writing in the event my e-mail address or phone number changes.

_____
PATIENT NAME

_____
E-MAIL ADDRESS (IF CONSENTING TO E-MAIL COMMUNICATIONS)

_____
PHONE NUMBER (IF CONSENTING TO PHONE CALLS)

_____
PHONE NUMBER (IF CONSENTING TO TEXT MESSAGES)

_____ _____
Signature of Patient/Personal Representative **Relationship to Patient**

FORM ID

BooneHealth

Patient Name:
Med Rec Number: Acct Number:
Age: Gender: DOB: Svc Date:

Health Insurance Portability and Accountability Act (HIPAA) - Release of Information

Patient's Name _____ Date of Birth: _____

I authorize my providers at BooneHealth to share information regarding my medical condition and care coordination with the following members of my support system:

Name: _____ Relationship: _____
Phone Number(s): _____ _____

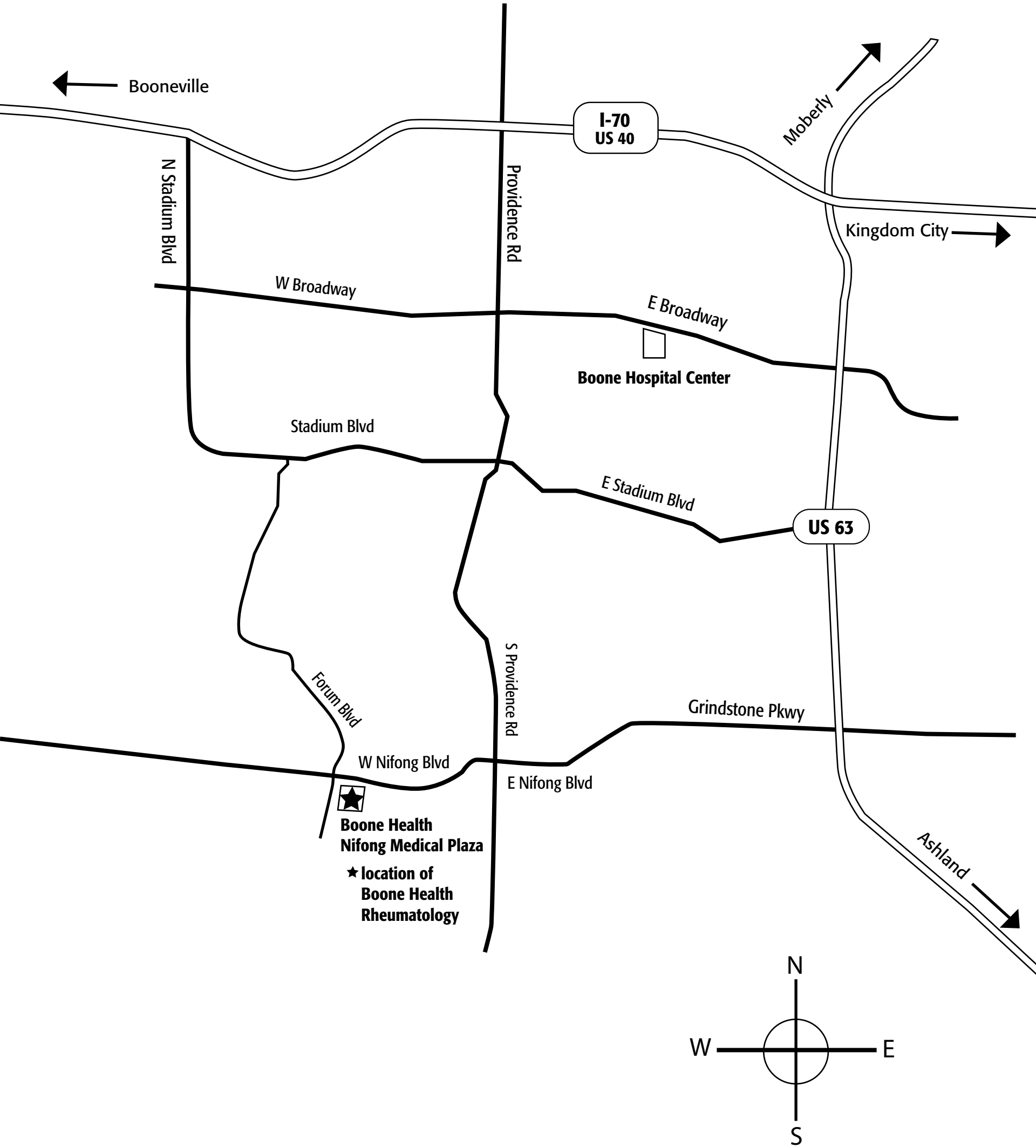
Name: _____ Relationship: _____
Phone Number(s): _____ _____

Name: _____ Relationship: _____
Phone Number(s): _____ _____

Name: _____ Relationship: _____
Phone Number(s): _____ _____

Name: _____ Relationship: _____
Phone Number(s): _____ _____

_____ _____
Patient Signature **Staff Signature**


Booneville
I-70
US 40
Moberly
Kingdom City
N Stadium Blvd
Providence Rd
W Broadway
E Broadway
Boone Hospital Center
Stadium Blvd
E Stadium Blvd
US 63
Forum Blvd
S Providence Rd
Grindstone Pkwy
W Nifong Blvd
E Nifong Blvd
Boone Health
Nifong Medical Plaza
★ location of
Boone Health
Rheumatology
Ashland
N
W
E
S