EMKEY ARTHRITIS AND OSTEOPOROSIS CLINIC
1200 Broadcasting Rd, Suite 200, Wyomissing, PA 19610
P- 610 374-8133 F- 610 375-1206

Welcome to our new patients!

On behalf of the providers and staff at Emkey Arthritis & Osteoporosis Clinic, we would like to welcome you to our practice! We are honored that you have chosen the Emkey Arthritis team to take part in your medical care.

Our Mission –

Excellence in medical care and clinical research ensuring compassion and the highest quality of life for each and every patient.

Please read the following which will provide our team with the essential information needed to give you the best care possible.

1) Please complete all the forms in this new patient packet and bring them with you to your first visit.
2) You will also need to bring the following items with you for your appointment:
   - ⇒ Your photo ID
   - ⇒ All insurance cards
   - ⇒ If your insurance company requires a referral (paper or electronic) please be sure to get one from your primary care physician prior to your appointment.
   - ⇒ All pharmacy cards
   - ⇒ A current list of all medications/supplements that you take, with dosages.

Please arrive 20 MINUTES prior to your scheduled appointment so our team may register you.

Your appointment is scheduled for ______________________ with _____________________.

It is important that your referring physician supplies us with all pertinent records so that your time at your visit can be used to your best advantage. Please call your physician to ensure your records have been sent to us.

If you have any questions, please call our office at 610-374-8133.

Our automated phone reminder service will come up on your caller ID as “610-795-9206”. It’s helpful to save this number in your contacts so that you recognize the automated appointment reminders.

We are so looking forward to meeting you!

Sincerely,

The Team at Emkey Arthritis & Osteoporosis Clinic, PC

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Directions from Allentown:
Merge onto US-22 West. Merge onto US-222 South towards Lancaster. Take the Broadcasting Road exit. Turn right onto Broadcasting Road. Follow Broadcasting Road. Cross over Papermill Road. Pass the Corporate Campus entrance and both ponds on your right. Turn right onto Meridian Blvd. Take the first right onto Commerce. The parking lot will be on your left.

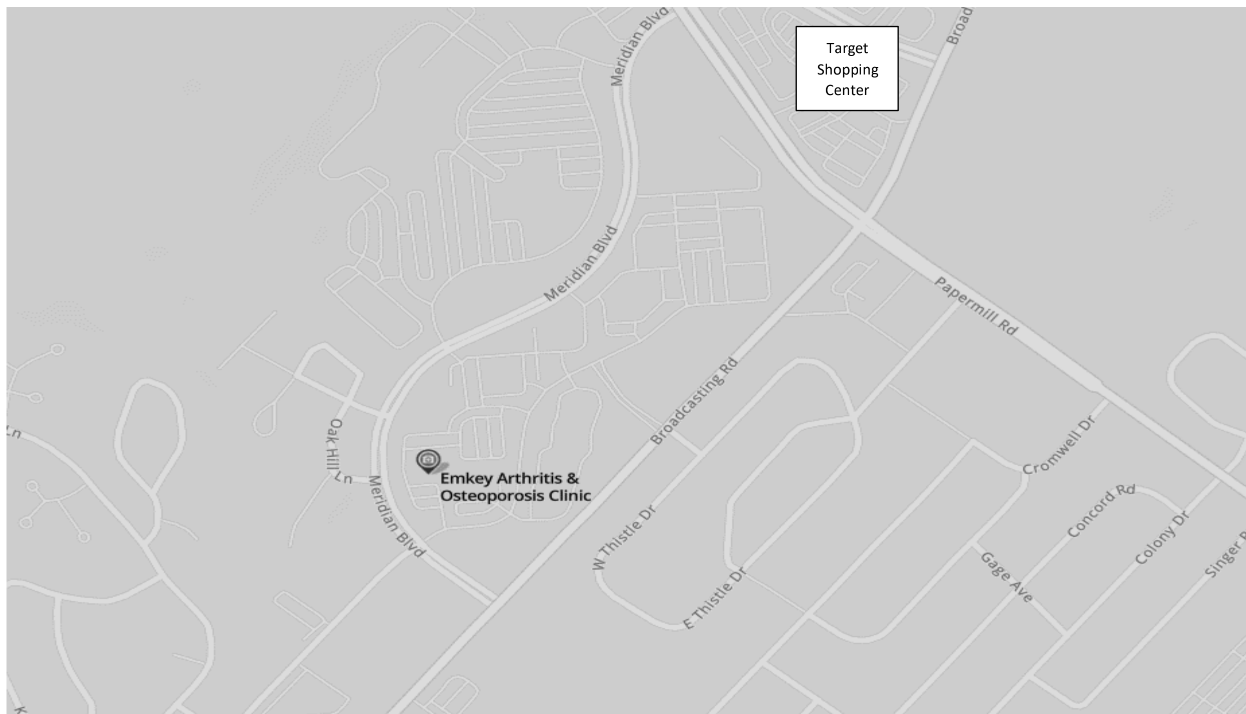
Directions from Harrisburg:
PA Turnpike East to exit 286 to Reading then follow directions from Pottstown below.

Directions from Pottstown/Philadelphia:
From the turnpike merge onto Morgantown Expressway /I-76 North via exit 298 toward Reading. Merge onto US-422 West via exit 118 on the left toward Reading. Merge onto US-222 North via the exit on the left toward Allentown. Take the Broadcasting Road exit, turn left onto Broadcasting Road. Continue on Broadcasting Road. Cross over Papermill Road. Pass the Corporate Campus entrance and both ponds on your right. Turn right onto Meridian Blvd. Take the first right onto Commerce. The parking lot will be on your left.

Directions from Ephrata/Lancaster:
Merge onto US-30 East/US 222 toward US 222 North. Bearing right towards Allentown. Take the Broadcasting Road exit. Turn left onto Broadcasting Road. Continue on Broadcasting Road. Cross over Papermill Road. Pass the Corporate Campus entrance and both ponds on your right. Turn right onto Meridian Blvd. Take the first right onto Commerce. The parking lot will be on your left.

Directions from Wernersville:
Take Penn Ave to 422 East. Merge onto US-222 via the exit on the left toward Allentown. Take the Broadcasting Road exit. Turn left onto Broadcasting Road. Continue on Broadcasting Road. Pass over Papermill Road. Pass the Corporate Campus entrance and both ponds on your right. Turn right onto Meridian Blvd. Take the first right onto Commerce. The parking lot will be on your left.

Directions from Route 12/Warren Street Bypass:
Exit onto Papermill Road. Turn left onto Broadcasting Road. Pass the Corporate Campus entrance and both ponds on your right. Turn right onto Meridian Blvd. Take the first right onto Commerce. The parking lot will be on your left.



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Notice of Information Practices and Privacy Statement

How We Collect Information About You: Emkey Arthritis and Osteoporosis Clinic (EAOC) and its employees and volunteers collect data through a variety of means including, but not limited to, letters, phone calls, emails, voicemails, and from the submission of applications that are either required by law or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation, medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voicemails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about patients, applicants or clients who apply for or actually receive our services that are considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your information or to provide you with health or counseling services which may require communication between EOAC and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to: obtaining or purchasing any type of medical supplies, devices, medications, or insurance.

If you apply, or attempt to apply, to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors except our website (www.emkeyarthritis.com) simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic data through our site. To avoid potential data capture, simply do not click on any of our outside affiliate links.

Limited Right to Use Non-Identifying Personal Information from Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of EAOC. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names, or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that no information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your consent.

Permission to leave detailed medical information message on: Home #_____ Cell # _____ Work # _______

Permission to speak with the following person(s) re: any portion of your medial information.

Name______________________________**Relationship**____________________**phone#**____________________

Name______________________________**Relationship**____________________**phone#**____________________

Name______________________________**Relationship**____________________**phone#**____________________

Print Name: ________________________________**Date of Birth:** ____________________

Signature: __________________________________**Date:** __________________________

HIPAA/Signature Date/Add to workflow - No

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FINANCIAL POLICY

Thank you for allowing the team at Emkey Arthritis & Osteoporosis Clinic to be part of your health care. We are honored and dedicated to providing you with the best possible care. We ask that you read the following policies and sign acknowledgement below.

Please be sure to bring your medical insurance card(s) to each visit.

Referrals / Authorizations: Since we are a specialist practice, your healthcare policy may require a referral from your primary care physician, and if this is the case, please obtain your referral and bring it to your appointment. If a referral cannot be obtained, we may have to cancel and reschedule your appointment until one has been issued. Our staff will take care of acquiring any prior authorizations needed for services and/or medications, however this does not guarantee your insurance will cover the cost.

High-Deductible Plans: If you participate with a high-deductible health plan, and if your deductible has not been met, we will bill your insurance and you will be receiving a patient statement with your portion of balance due.

Out of Network Plans: It is your responsibility to understand your out-of-network benefits. Payment will be expected at the time of service, and we will provide you with an invoice that you can submit to your insurance for reimbursement.

In Network Plans: We are contracted with your insurance and are expected to collect from you at the time of service any co-pays, deductibles and out of pocket portions. For your convenience, we accept payment by cash, check, or credit card. Please be prepared to pay at your appointment. If you have any questions as to what your responsibility would be, you may contact your insurance.

Patient Balances: We will bill you any patient coinsurance, deductible and/or member portion that your insurance states are your responsibility. Should you receive a patient statement in the mail the office expects full payment within 30 days. If you are unable to pay in full, it will be your responsibility to contact our billing office to set up an agreed upon payment arrangement. The billing office phone number is 610 374-8133 option 6. If your bill goes unpaid for >90 days, your appointments will be suspended, and your account will go to collections. Guarantor agrees to be responsible for all costs of collection on unpaid balances including, but not limited to, 1.5% interest (18% annually), collection fees (up to 50%), court costs and reasonable attorney fees.

Returned Checks: There is a $45.00 fee for each returned check.

Cancellation of Appointments: 24-hour notice is required if you need to cancel or reschedule your appointment. We have an extensive waiting list, and this allows others the opportunity to be seen.

Missed Appointments: If you did not cancel 24 hours prior and missed your appointment there will be a fee of $75.00 for established patients and $125.00 for new patients charged to your account.

Medical Record Transfer Fees: If you are requesting your medical records, there will be a fee per page which is determined by the Pennsylvania Department of Health. Once payment is received, we will release records to you within 5 business days.

Additional Forms: (i.e., Disability & Family Medical Leave Forms, Worker's Compensation and Parking Placard forms) There is a charge for the completion of forms. It is $10 for the first page and $5 for every page thereafter. FMLA forms are $45 charge. Forms will be completed upon receipt of the payment by cash, check or credit card.

MY SIGNATURE BELOW ACKNOWLEDGES THE FOLLOWING:

- **I AM RESPONSIBLE FOR ANY MEDICAL EXPENSES NOT COVERED BY MY HEALTH INSURANCE PLAN.**

Print Name: ____ **Date of Birth:** ____________________

Signature: ____ **Date:** ___________________________

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NEW PATIENT DEMOGRAPHIC FORM

Name: ____ Date of Birth: _____/_____/______

Age: ______ Gender (circle one): Male Female

Address: ____

City: ____ Zip: ____________________________

Home phone #: _________________________________ Mobile phone #: _______________________________

Email address (required for our portal): ____

Patient Work Status (Please circle one): Full-time Part-time Student Retired Other: _______________________

Patient's Employer: ____ Work Phone #: __________________________

Employer's Address: ____

Patient Marital Status (Please circle one): Single Married Divorced Separated Widowed

Spouse's Name: ____Spouse Date of Birth: ___/___/____

Spouse's Address: ____

Spouse's Employer: ____

Emergency Contact: ___________________________________Relationship: __________ Phone #: ________________

Primary Insurance: ____

Subscriber's Name: ____ Date of Birth: ___/___/____

Relationship: ____________________________________ ID #: ______________________Group #_________________

Secondary Insurance: ____

Subscriber's Name: ____ Date of Birth: ___/___/___

Relationship: _____________________________________ ID #: ______________________Group #: _______________

Family Physician: ____ Phone #: _________________________

Referring Physician: ____ Phone #: __________________________

Is your visit related to an open insurance claim for a car accident or workman's compensation? Yes______ No_______

If yes, please provide the following information: Date of Injury: _____ /______/______

Claim Carrier: ____Claim ID #: __________________________________

Claim Adjustor's Name & Phone #: ____

Description of Injury: ____

____

Revised 10/2023

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NEW PATIENT HISTORY FORM

Name: ____ **Date of Birth ____/_____/_____**

Education: Grade School__________ High School _________ College _________ Graduate School _____________

Occupation: ____ # of hours worked per week (average)_____________

Referred by (check one): Self _____ Family _____ Friend ______ Doctor ______ Web _______ Other ________________

Name of Referring Physician*:* ____

Primary Care Physician: ____

Do you have an orthopedic surgeon? Yes____ No____ If yes, name:_____________________________________

Briefly describe your present symptoms: ____

____

Date symptoms began (approximate):______/______/_______Diagnosis: _________________________________

____

Previous treatment for this problem (include physical therapy, surgery, medications, and injections)*:*___________________

____

Please list the name(s) of other practitioner(s) you have seen for this problem: ______________________________

____

Medical History (please list all medical problems for which you have been diagnosed and treated):

____________________; __________________; ____________________; ____________________; ____________________;

____________________; __________________; ____________________; ____________________; ____________________;

____________________; __________________; ____________________; ____________________; ____________________

<u>Surgical History</u> (please list all previous operations, name of hospital, reason for surgery and approximate dates):

____

____

____

____

<u>Family History</u> (please give any pertinent medical history of family members):

Mother ____

Father ____

Siblings ____

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NEW PATIENT HISTORY FORM cont'd

Name____

Social History
Caffeine: Yes No Servings per day _________ Type: [ ]Chocolate [ ]Coffee [ ]Energy Drinks [ ]Soda [ ]Tea
Alcohol: Yes No Avg # drinks ____ [ ]Daily [ ]Occasionally [ ]Rarely [ ]Socially Type: [ ]Beer [ ] Liquor [ ]Wine
Tobacco Use: Yes No Previous Quit Date_________________
Nicotine Vapor: Yes No If yes how long __________________
Illicit Drug Use: Yes No If yes types of drugs ________________________________
Exercise: Yes No If yes type of exercise _______________________________

How many hours of sleep do you get a night? _________________

Do you wake up feeling rested? [ ]Yes [ ]No

Have you had any recent falls? [ ]Yes [ ]No

Medications (please list ALL medicines you are currently taking, including non-prescription, vitamins and supplements):
Name____________________________ Dosage_______________________ Frequency___________________________

Name____________________________ Dosage_______________________ Frequency___________________________

Name____________________________ Dosage_______________________ Frequency___________________________

Name____________________________ Dosage_______________________ Frequency___________________________

Name____________________________ Dosage_______________________ Frequency___________________________

Name____________________________ Dosage_______________________ Frequency___________________________

Name____________________________ Dosage_______________________ Frequency___________________________

Allergies (please list all allergies and bad reactions to medicines and medical products):

____

____

Name of Preferred Pharmacy: ___________________________________ Phone Number:__________________________

Pharmacy Location: ____
When did you have your last:

PCP visit: _____________________ DEXA scan: _________________________ Mammogram: ______________________

Visual field exam: ________________TB/PPD test: ___________________ Flu vaccine: ____________________________

Pneumonia vaccine(s): Pneumo-Vax (primary) _____________________ Prevnar 13 (booster) _______________________

COVID-19 Vaccine:
Manufacturer: Moderna__________________ Pfizer_____________________ Johnson & Johnson__________________

Primary Vaccine: 1st Vaccine Date _________________________ 2nd Vaccine Date _______________________________

Booster: _____________________ /________________________ /_________________________ /____________________
1ST 2ND 3RD 4TH

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SYSTEMS REVIEW/REVISIÓN DE SISTEMAS

Name/*Nombre*___________________________ Date/*Fecha*_______________

CONSTITUTIONAL/*CONSTITUCIONAL*

- ☐ Recent weight gain____________lbs *Subida de peso reciente ________libras*
- ☐ Recent weight loss ___________lbs *Perdida de peso reciente__________libras*
- ☐ Fatigue/*Fatiga*
- ☐ Night sweats/*Sudoras noctornos*
- ☐ Change in appetite *Cambio en el apetito*

EYES/*OJOS*

- ☐ Pain/*Dolor*
- ☐ Redness/*Enrojecimiento*
- ☐ Loss of vision/*Perdida de la vision*
- ☐ Double blurred vision *Vision doble borrosa*
- ☐ Dryness/*Sequedad*
- ☐ Feels like object in eye *Se siente como un objeto en el ojo*
- ☐ Itchy eyes/*Picazon en los ojos*

EARS/NOSE/ THROAT/ MOUTH
OIDOS/NARIZ/GARGANTA/BOCA

- ☐ Ringing in ears/*Zumbidos en los oidos*
- ☐ Loss of hearing/*Perdida de audicion*
- ☐ Nosebleeds/*Hemmorragias nasales*
- ☐ Loss of smell/*Perdida del olfato*
- ☐ Tongue pain/*Dolor de lengua*
- ☐ Jaw pain with chewing *Dolor de mandibula al masticar*
- ☐ Bleeding gums/*Sangrado de encias*
- ☐ Sores in mouth/*Llagas en la boca*
- ☐ Dry mouth/*Boca seca*
- ☐ Frequent sore throats *Dolores de garganta frecuentas*
- ☐ Hoarseness of voice/*Ronquera de la voz*
- ☐ Difficulty swallowing/*Dificultad para tragar*

CARDIOVASCULAR/*CARDIOVASCULAR*

- ☐ Chest pain/*Dolor de pecho*
- ☐ Irregular heart rate/*Ritmo cardiaco irregular*
- ☐ Sudden change in heartbeat *Cambio repentido en los latidos del corazon*
- ☐ High blood pressure/*Pression arterial alta*
- ☐ Heart murmurs/*Soplos cardiacos*
- ☐ Swollen legs or feet *Piernas o pies hinchados*
- ☐ Color change in hands/feet in cold *Cambio de color en manos/pies en frio*

ENDOCRINE/*ENDOCRINO/A*

- ☐ Excessive thirst/*Sed excesiva*

MUSCULOSKELETAL/*MUSCULOESQUELETICO*

- ☐ Morning stiffness lasting how long?_____ *Cuanto dura la rigidez matutina?________*
- ☐ Joint pain/*Dolor en las articulaciones*
- ☐ Muscle weakness/*Debilidad muscular*
- ☐ Muscle tenderness/*Sensibilidad muscular*
- ☐ Joint swelling/*Hinchazon de las articulaciones*

GASTROINTESTINAL/*GASTROINTESTINAL*

- ☐ Nausea/*Nauseas*
- ☐ Vomiting/*Vomitos*
- ☐ Stomach pain relived with food *Dolor de estomago que se alivia con la comida*
- ☐ Jaundice/*Ictericia*
- ☐ Increasing constipation *Aumento del estrenimiento*
- ☐ Persistent diarrhea/*Diarrea persistente*
- ☐ Blood in stools/*Sangre en las heces*
- ☐ Heartburn/*Acidez estomacal*

GENITOURINARY/ GENITOURINARIO/A

- ☐ Difficulty urinating/*Dificultad para orinar*
- ☐ Pain or burning on urination *Dolor o ardor al orinar*
- ☐ Blood in urine/*Sangre en la orina*
- ☐ Cloudy urine/*Orina turbia*
- ☐ Pus in urine/*Pus en la orina*
- ☐ Discharge from penis/vagina *Secrecion del pene/vagina*
- ☐ Frequent nighttime urination *Miccion noturna frecuente urinacion*
- ☐ Rash or ulcers/*Ronchas o ulceras*
- ☐ Sexual difficulties/*Dificultades sexuales*

INTEGUMENTARY (skin/breast)
INTEGUMENTARIO (piel/mama)

- ☐ Easy bruising/*Moretones faciles*
- ☐ Redness/*Enrojecimiento*
- ☐ Rash/*Ronchas*
- ☐ Hives/*Urticaria*
- ☐ Sun sensitivity/*Sensibilidad al sol*
- ☐ Tightness of skin//*Tirantez de la piel*
- ☐ Nodules/ bumps/*Nodulos/protuberancias*
- ☐ Hair loss/*Perdida de cabello*
- ☐ Changes to nails/*Cambios en las uñas*

FOR WOMAN ONLY/*SOLO PARA MUJER*

- ☐ Age of onset of period_______________ *Edad de inicio del periodo_____________*
- ☐ Periods regular?/*Periodos regulares?____*
- ☐ Every how many days?_________ *Cada cuantos dias?____________*
- ☐ Date of last period?_________________ *Fecha del ultimo periodo?_____________*
- ☐ Date of last PAP? ___________________ *Fecha del ultimo PAP?________________*
- ☐ Bleeding after menopause? ___________ *Sangrado despues de la menopausia?____*
- ☐ # Pregnancies____ # Miscarriages_____ *# Embarazos_____#Aborotos natural_____*

NEUROLOGIAL/ NEUROLOGICO/A

- ☐ Headaches/*Dolores de cabeza*
- ☐ Dizziness/*Mareos*
- ☐ Fainting/*Desmayo*
- ☐ Muscle Spasms/*Espasmos musculares*
- ☐ Loss of consciousness *Perdida del conocimiento*
- ☐ Numbness/tingling hand or feet *Entumecimiento/hormigueo en mano o pies*
- ☐ Memory loss/*Perdida de memoria*

PSYCHIATRIC/*PSIQUIATRICO/A*

- ☐ Excessive worry/*preocupacion excesiva*
- ☐ Anxiety/*Ansiedad*
- ☐ Depression/*Depresion*
- ☐ Difficulty falling asleep *Dificultad para conciliar el sueño*
- ☐ Difficulty staying asleep *Dificultad para quedarse dormido/a*

RESPIRATORY/ RESPIRATORIO/A

- ☐ Shortness of breath/*Dificultad para respirar*
- ☐ Difficulty breathing at night *Dificultad para respirar por la noche*
- ☐ Cough/*Tos*
- ☐ Coughing up blood/*Tos con sangre*
- ☐ Wheezing/*Sibilancias*

HEMATOLOGY/LYMPHATIC
HEMATOLOGIA/LINFATICO

- ☐ Swollen glands/*Glandulas inflamadas*
- ☐ Tender glands/*Glandulas sensibles*
- ☐ Bleeding tendency/*Tendencia al sangrado*
- ☐ Transfusion date____________________ *Fecha de transfusion__________________*

Physician's Initial's_____________________