Pine Hollow Partners, LLC
6200 Pine Hollow Dr Suite 400
East Lansing, MI 48823
PH: 517-339-1676
Fax: 517-339-2716

Iris Zink, MSN, ANP-BC, APRN
Christopher Title,MSN, FNP-BC, APRN
Claudia Rivera-Salas, DNP,APRN, NP-C
Katherine Bursma, MSN, FNP-BC, APRN

NAME: _____ PREFERRED NAME: _____ SEX: _____

DATE OF BIRTH: _____ AGE: _____ E MAIL: _____

GENDER IDENTITY

GENDER IDENTITY (MALE, FEMALE, TRANSGENDER, OTHER): _____ SEXUAL ORIENTATION: _____

PREFERRED PRONOUNS (CIRCLE ONE SET)

HE/HIS SHE/HER THEY/THEIR

PERSONAL INFORMATION

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: _____ OTHER PHONE: _____

REFERRED BY (CIRCLE ONE):

SELF FAMILY FRIEND PRIMARY CARE OTHER

NAME OF THE PERSON WHO REFERRED YOU: _____

PRIMARY CARE PROVIDER: _____

PRIMARY CARE PROVIDER PHONE NUMBER: _____

DO YOU HAVE A CURRENT ORTHOPEDIC PROVIDER? YES NO

IF YES, NAME AND PHONE NUMBER: _____

PREFERRED PHARMACY: _____

PHARMACY ADDRESS AND PHONE NUMBER IF KNOWN:

_____

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Ethnicity

- ❑ Hispanic or Latino
- ❑ Non-Hispanic or Latino
- ❑ Decline

Race

- ❑ American Indian or Alaskan Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian/Pacific Islander
- ❑ Caucasian
- ❑ Other

Insurance Information

Primary insurance company: _____

Subscriber Name: _____ Date of Birth: _____
Relationship: _____ Phone: _____

Contract/Policy #: _____ Group #: _____ Co-pay: _____

Secondary insurance company: _____

Subscriber Name: _____ Date of Birth: _____

Contract/Policy #: _____ Group #: _____ Co-pay: _____

Emergency Contact Information

Please inform us of any changes

Name: _____ Relationship: _____

Phone: _____

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BRIEFLY DESCRIBE YOUR SYMPTOMS

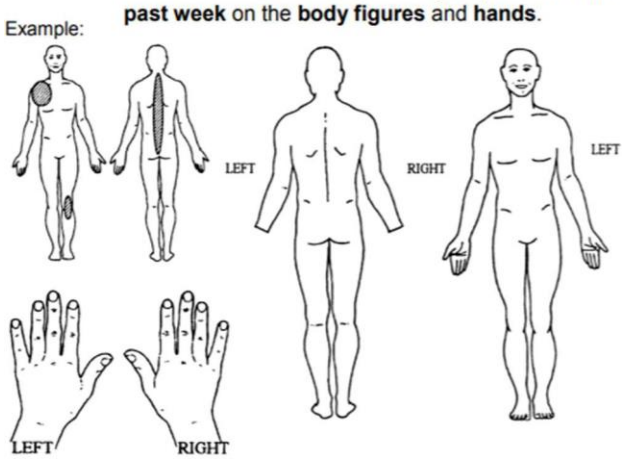
DATE SYMPTOMS BEGAN: _____

PREVIOUS TREATMENTS: (E.G., PHYSICAL THERAPY, SURGERY, INJECTIONS)

DO NOT INCLUDE PRESCRIPTIONS OR MEDICATIONS

LIST THE PROVIDERS WHO HAVE TREATED OR ARE CURRENTLY TREATING YOU FOR THESE CONCERNS

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.



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Past Medical History

Condition	✓	Year(s)	Solved
Rheumatic Fever			
Tuberculosis			
Hepatitis			
HIV			
Gonorrhea			
Chlamydia			
Uveitis/Iritis			
Cancer			
Food Poisoning			
Osteoporosis			
Fracture or Broken Bone			
Mental Illness			
Blood Clot			

Please list any significant medical history not mentioned above

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Allergies

❑ I HAVE NO KNOWN ALLERGIES

Name of Medicine/Other Allergy	Type of Reaction

Surgical History

Include inpatient and outpatient operations here

Procedure	Year	Reason

Past Hospitalizations

Only include hospital admissions in which no surgical intervention occurred

Hospitalization	Year	Reason

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Family Medical History

Please specify maternal or paternal grandparents, mother, father, sister, brother

❑ I was adopted

Condition	Relative(s)
Diabetes	
Cancer	
Crohn's/Ulcerative Colitis	
Psoriasis	
Ankylosing Spondylitis	
Fibromyalgia	
Osteoporosis	
Rheumatoid Arthritis	
Gout	
Celiac Disease	
Other Autoimmune Disease (please specify)	

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Social History

Marital Status

☐ Never Married ☐ Married ☐ Divorced
☐ Separated ☐ Widowed

Spouse/Significant Other

Alive? Yes or No Age: _____ Major Illness: _____

Number of children: _____ **Number of children living at home:** _____

Highest level of education completed: _____

Occupation

❑ I AM UNEMPLOYED

❑ I AM ON DISABILITY

Occupation: _____ Hours per week: _____

CAFFEINE INTAKE: MILD MODERATE HEAVY

ALCOHOL INTAKE: MILD MODERATE HEAVY

HAS ANYONE EVER ASKED YOU TO CUT DOWN ON DRINKING? YES OR NO

ARE YOU A CURRENT SMOKER? YES OR NO

Did you ever smoke? Yes or No Date Quit: _____

DO YOU USE DRUGS FOR ANY NON-MEDICAL REASON? YES OR NO

If yes, please list: _____

DO YOU EXERCISE REGULARLY? YES OR NO

How many times a week? _____ Intensity: (mild, moderate, heavy)

How many hours do you sleep per night? _____

Do you get enough sleep at night? Yes or No Do you rested when you wake up? Yes or No

DO YOU FEEL SAFE IN YOUR HOME ENVIRONMENT? YES OR NO

IS YOUR SEX LIFE SATISFACTORY? YES OR NO

If not, please elaborate: _____

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Current Medications

Please list all current prescription medications, over-the-counter medications, and supplements

❑ I do not take any medicine

Name	Dose	Frequency

Past Medications

Please check all medications that you have taken in the past.
Also indicate whether they were tolerated and helpful.
If they were discontinued, write the reason.
Note only what you are NOT already taking.

Medication	Taken	Tolerated	Helpful	Reason Discontinued
Arava (Leflunomide)		YES/ NO	YES/ NO	
Sulfasalazine (Azulfadine)		YES/ NO	YES/ NO	
Methotrexate		YES/ NO	YES/ NO	
Plaquenil (Hydroxychloroquine)		YES/ NO	YES/ NO	

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Adverse Childhood Experience (ACE) Questionnaire

Before your 18th birthday:

1. Did a parent or another adult in the household often or very often… Swear, insult, put you down, or humiliate you? Or act in such a way that you were afraid that you might be physically hurt?

No _____If the answer is YES enter 1_____

2. Did a parent or another adult in the household often or very often… Push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?

No _____If the answer is YES enter 1_____

3. Did a parent or another adult in the household often or very often… Touch or fondle you or have you touch their body in a sexual way? Have or attempt to have oral, anal, or vaginal intercourse with you?

No _____If the answer is YES enter 1_____

4. Did you often or very often feel that… No one in your family loved you or thought you were special or important? Or your family didn't look out for each other, feel close to each other, or support each other?

No _____If the answer is YES enter 1_____

5. Did you often or very often feel that… You didn't have enough food, had to wear dirty clothes, and had no one to protect you? Or were your parents too drunk or high to take care of you or take you to the doctor if you needed it?

No _____If the answer is YES enter 1_____

6. Were your parents ever separated or divorced?

No _____If the answer is YES enter 1_____

7. Did your mother or stepmother: Often or very often push, grab, slap, or throw something at you? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

No _____If the answer is YES enter 1_____

8. Did you live with someone who was a problem drinker or alcoholic, or who used street drugs?

No _____If the answer is YES enter 1_____

9. Was a household member depressed or mentally illness, or did a household member attempt suicide?

No _____If the answer is YES enter 1_____

10. Did a household member go to prison?

No _____If the answer is YES enter 1_____

Now, add up your "YES" answers: _____

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Patient Health Questionnaire (PHQ-9)

	HOW OFTEN HAVE YOU BEEN BOTHERED BY THE FOLLOWING OVER THE PAST 2 WEEKS?	Not at all	Several Days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things?				
2	Feeling down, depressed, or hopeless?				
3	Trouble falling or staying asleep, or sleeping too much?				
4	Feeling tired or having little energy?				
5	Poor appetite or overeating?				
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down?				
7	Trouble concentrating on things, such as reading the newspaper or watching television?				
8	Moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual?				
9	Thoughts that you would be better off dead, or thoughts of hurting yourself in some way?				

For office coding _____+_____+_____+_____

Total Score = _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (circle one)

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

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HIPAA Patient Consent

Our Notice of Privacy Practices provides information about how we may use and disclose protected health about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The Terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to accept this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing with a written consent signed by you. However, such revocation shall not affect any disclosure we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but the Practice does not have to accept those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by:

_____
Printed Name of Patient or Responsible Party

_____
Patient Signature or Signature of the Responsible Party

_____
Relationship to Patient (If other than Patient)

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Welcome!

Welcome to Iris Zink's Nurse Practitioner office. Nurse Practitioners (NPs) are advanced practice nurses with at least a Master's degree who were supervised by a physician during their education and must pass specialty certifications in order to practice.

Based on the Public Act 499 Of 2016 (HB 5400), the passage of HB 5400 (signed by Governor Snyder on January 9, 2017 with new terms as of April 9, 2017) improves NP practice in Michigan in the following ways: defined Advanced Practice Registered Nurse (APRN), authorized NPs to prescribe non-scheduled pharmaceuticals independently, and authorize NPs to order Physical Therapy, Speech Therapy, and Occupational Therapy.

Iris Zink has been a Rheumatology Nurse Practitioner since September 2000. She has been the President of the Society of the Rheumatology Nurses Society, which is a national post and is considered a key opinion leader in the Rheumatology community. She is an adjunct faculty at Michigan State University and has given more than 100 lectures and published many articles on various topics in Rheumatology.

By signing this agreement,

_____

SIGNATURE

You agree that your care will be provided by a Nurse Practitioner.

If at any time Iris Zink, Christopher Title, Claudia Rivera-Salas, Or Katherine Bursma have questions about your care, we will consult with another rheumatologist in the United States.

If at any time you wish to see a rheumatologist or get a second opinion, we will gladly assist in providing a referral to another practice.

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Patient Authorization for Personal Representative Form

Patient Name: _____

Purpose of the form:

I authorize Lansing Rheumatology/NPRC to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may consent to or authorize the use of the disclosure of my protected health

INFORMATION:

Name of Personal Representative	Relationship	Phone Number

❑ I DO NOT AUTHORIZE ANYONE TO ACT AS MY PERSONAL REPRESENTATIVE AT THIS TIME

- **DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:** I AUTHORIZE LANSING RHEUMATOLOGY/NPRC TO DISCLOSE ALL OF MY PROTECTED HEALTH INFORMATION TO MY DESIGNATED PERSONAL REPRESENTATIVE.
- **EXPIRATION OR TERMINATION OF AUTHORIZATION:** THE AUTHORIZATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY YOU, YOUR PERSONAL REPRESENTATIVE, OR ANOTHER INDIVIDUAL(S) OF LEGAL ENTITY TO DO SO BY COURT ORDER OR LAW.
- **RIGHT TO REVOCATION OR TERMINATION:** AS STATED IN OUR NOTICE OF PRIVACY PRACTICE, YOU HAVE THE RIGHT TO REVOKE OR TERMINATE THIS AUTHORIZATION BY SUBMITTING A WRITTEN REQUEST TO OUR PRIVACY MANAGER. THIS CAN BE DONE IN-PERSON OR BY MAILING A REQUEST TO LANSING RHEUMATOLOGY/NPRC.
- **RE-DISCLOSURE:** WE HAVE NO CONTROL OVER THE INDIVIDUAL YOU HAVE INCLUDED AS YOUR PERSONAL REPRESENTATIVE. THEREFORE, THE PROTECTED HEALTH INFORMATION DISCLOSED UNDER THIS AUTHORIZATION WILL NO LONGER BE PROTECTED BY THE REQUIREMENTS OF THE PRIVACY RULE AND WILL NOT BE THE RESPONSIBILITY OF LANSING RHEUMATOLOGY/NPRC.

Signature of the patient: _____ Date: _____