North Texas Joint Care, P.A.
Leyka M. Barbosa, M.D., F.A.C.R.

7777 Forest Lane, Suite C-502
Dallas, Texas 75230

Telephone: (972)566-6599
Fax: (972)566-6611

Dear Patient:

Thank you for contacting North Texas Joint Care, P.A. to schedule an appointment. We are delighted to welcome you to our private practice in adult rheumatology at the above address. Please visit our website at www.jointcare.org; your comments can be emailed by clicking on 'Mark'.

Rheumatology is the area of internal medicine which manages the diagnosis, treatment and prevention of autoimmune, musculoskeletal and arthritic conditions. These include osteoarthritis, rheumatoid arthritis, lupus, Sjogren's syndrome, vasculitis, scleroderma, bursitis, tendonitis, carpal tunnel syndrome, fibromyalgia, chronic fatigue and chronic pain syndromes, as well as other less common conditions. Please ask us about recent developments in rheumatology, such as targeted Biologics for RA, Lupus, and Chronic Gout, viscous knee injectables, and other anti-rheumatic therapies.

Office hours are 8:30 a.m. to 12:30 p.m. and 1:30 p.m. to 4:30 p.m., Monday through Thursday, and some Friday mornings, with exceptions. We close for lunch from 12:30 p.m. to 1:30 p.m. Please complete and bring the attached documents, & arrive 15 minutes before your first scheduled appointment (Consult) to establish your registration. If you are late for the Consult visit, be prepared to be rescheduled; a NO SHOW fee may apply as 1 hour of Physician time has been reserved. For all HMO, POS, and EPO patients, a referral is required. All patients must have a primary care physician, as my practice is by referral consultation only. Your insurance card, driver's license and co-pay must be furnished at the time of your visit.
We very much look forward to meeting you. Best regards.

Sincerely,

Leyka M. Barbosa, M.D., F.A.C.R.
Director, North Texas Joint Care

North Texas Joint Care, P.A.; 7777 Forest Lane, Suite C-502
Dallas, TX 75230-2548; tel 972-566-6599; fax 972-566-6611

Patient Consent for Use of Email Communications

This office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at **mark@jointcare.org** . Please consider that this form of communication is not appropriate for use in an emergency. It is not required or expected of our patients to use Email with us, this is just a desired convenience for those who want it.
The turnaround time for routine patient communications is 1 day with delays expected before, during, & after holidays and dates when the office is closed as posted on the voicemail. And the service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, patient ID number and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff and /or colleagues would have access to this information.

Patient designated Email address: _____

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond our control.

I understand and agree to the above email policy.

By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails via return email.

_____ _____
Patient signature Witness (optional)

_____
Date

North Texas Joint Care, P.A.
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7777 Forest Lane, Suite C- 502
Dallas, Texas 75230

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The following policies have been put into effect by our office regarding payment of office visit fees. These policies are designed to reduce expensive paperwork and secretarial services, which may otherwise force us to raise charges to our patients. Your cooperation is appreciated.

1. **OFFICE VISITS** – Payment is expected at the time services are rendered. We will help you by filing your insurance for the covered portion. The deductibles and non-covered portions are due at the time of service. For your convenience, we prefer cash, or check, however, we accept Visa and MasterCard. If you are more than **30 minutes** late, we may need to reschedule your appointment.
2. **ROUTINE VISITS** – Most insurance plans cover 80-100% of your visits. Some insurance policies have deductibles and/or copayments; some do not. If your insurance does not pay its portion within sixty days, you will be called upon to assist in the collection/payment process. Regrettably, it is possible that an appointment may be delayed or rescheduled when accounts are significantly behind. Forms and correspondence completion are payable in advance (see fee schedule); medical records copies are completed and billed by a subcontractor (usually a free service for one provider to another).
3. **MEDICAL INSURANCE** – Medical insurance plans vary widely in their coverage of services. Your contract is an agreement between you and the insurance company. This contract does not obligate the doctor to charge a specific fee or to accept reimbursement from your insurance company as payment in full, unless the contracted amount is paid on time. You will remain responsible for the uncovered balance. Complaints or inquiries about insurance coverage should be directed to your insurance agent, the Texas Department of Insurance, and to the United States Dept. of Labor for ERISA/Employer Sponsored plans; the staff at Medicare can be reached about those inquiries or complaints. Our business manager is available to consult in drafting such complaint correspondence(s), as we have mutual interests at stake.
4. **PREAUTHORIZATION OF BENEFITS** – In some instances, pre-authorization of benefits is required from your insurance carrier. This is true of all major rheumatological procedures such as injections, aspirations, etc. We may file a pre-authorization to make sure your insurance will cover a prescribed procedure; currently, we need a separate "commitment to pay" certification also. Emergency procedures need no pre-authorization. If you decide to forego the pre-authorization, then you are totally responsible to pay personally at the point of service. Pre-authorizations are limited to the dates approved. Beyond that point, prices may increase or insurance benefits may change or expire.
5. **INSURANCE CHECKS** – Should your insurance company send your reimbursement check to us, we will make every effort to submit the payment back to you, and to refund overpayments to the appropriate party.
6. **NO-SHOW POLICY** – We require **one full business day** notice to reschedule or cancel an appointment (for example, call Friday morning regarding the following Monday). You may leave a voice message recording at any hour. We attempt to confirm your appointment twenty-four hours in advance by phone. Our no-show policy fee for a **broken appointment is $50** for less than 1 (one) business day of notice. We do understand that things beyond your control can occur. If this is the case, please call. We understand your time is valuable and make every effort to see you at your scheduled time. **Initial:** _____
7. **COLLECTIONS** – All charges are payable within sixty days. Unpaid accounts force us to raise our fees. Because of this, we are committed to pursue any unpaid account balances. Unpaid accounts will be referred to a professional collection agency or pursued in the courts; NSF checks must be refunded to us immediately. If you have a financial problem, special arrangements can be made if notification is given to our office at the earliest possible moment.
8. **RETURNED CHECK POLICY** - Fee of $25.00 plus amount of check due immediately; Payment in cash, money order or cashier's check.
9. **FEE FOR SERVICE** – Payment is required at the time services are rendered. For your convenience, we prefer cash, or check; however, we accept Visa and MasterCard. Regrettably and unfortunately we must pass on the cost of excessive re-billing/data analysis for unpaid visits, services and material that is re-billed 3 or more times or unpaid for 120 days: CPT code #99080, institutional charge $250.00, patient charge $50.00 (both subject to change) **Initial:**_____
10. **MEDICAL RECORDS** - All medical records are copied weekly, by a subcontracted records copying company, and require a signed records release form. Please note that it may take 10-15 business days for the records to reach their destination.

We appreciate your cooperation,
NORTH TEXAS JOINT CARE, P.A.

Patient Signature:_____; Date:_____
(Insured / Guardian / Authorized Representative)

Registration *(please print)*

Leyka M. Barbosa, M.D.

North Texas Joint Care, P. A.;
7777 Forest Lane, Suite C- 502
Dallas, TX 75230

Today's Date: _____

Patient's Name:_____ **DOB:**_____/_____/_____ **SEX: Male Y Female Y**

Social Security Number: _____-_____-_____

Patient's Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (____)_____-_____ **Work Phone:** (____)_____-_____

MARITAL STATUS: Never Married Y Married Y Divorced Y Widowed Y Separated Y

OCCUPATION: Employer: _____ **Profession:** _____

Address:_____**City:**_____**State:**_____**Zip:**_____
Is your injury work related? Please circle: No (N) Yes (Y) (If yes, explain)_____

Referring Physician, or Primary Care Physician: _____

Reason For Your Visit: _____**Onset Date of Current Symptoms** ____/____/____

Emergency Contact Name: _____**Phone Number:** (____) _____**Relationship:**_____

Primary Insurance Information

Primary Insurance _____ **HMO PPO POS EPO OTHER**

Insured's Name _____; **Relationship To Patient: SELF SPOUSE DEPENDANT OTHER**_____

Insured's Date of Birth: _____/_____/_____ **Insured's Social Security Number:**_____-_____-_____

Insured's ID Number: _____**Group Number:** _____

Insurance Company Phone Number: (____)_____; **Insured's Employer & Benefits Address:** _____

Secondary Insurance Information

Is There a Secondary Insurance? (If yes, what is it?)_____

Insured's Name:_____**Relationship To Patient: SELF SPOUSE DEPENDANT OTHER**_____

Insured's Date of Birth: _____/_____/_____ **Insured's Social Security Number:** _____-_____-_____

Secondary ID Number: _____**Group Number:** _____

Secondary Ins. Company Phone Number:(____)_____-_____; **Insured's Employer & Benefits Address:** _____

ASSIGNMENT AND RELEASE AND CONSENT TO CARE

I, the undersigned, have insurance coverage with (Primary Ins.)_____, **& (SecondaryIns.),**_____, **& (Tertiary Ins.)**_____ **and assign directly to Dr. Leyka Barbosa, (North Texas Joint Care, P. A.) all medical benefits and authority to appeal (for Pre-authorization denials, late/short/or non-payments) under ERISA or state jurisdiction, if any otherwise payable to me for services rendered. I understand that I am financially responsible for copays, deductibles, and any uninsured services. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I also hereby give my consent to the physician(s) of North Texas Joint Care, P.A. for medical treatment.**

X_____ _____

SIGNATURE OF INSURED, GUARDIAN or AUTHORIZED REPRESENTATIVE **DATE OF SIGNATURE**

AMERICAN COLLEGE OF RHEUMATOLOGY

EDUCATION • TREATMENT • RESEARCH

Patient History Form

Date of first appointment: ____/____/____ (MONTH DAY YEAR) Time of appointment: _____ Birthplace: _____

Name: _____ (LAST FIRST MIDDLE INITIAL MAIDEN) Birthdate: ____/____/____ (MONTH DAY YEAR)

Address: _____ (STREET) Age: _____ Sex: ☐ F ☐ M

_____ (CITY STATE ZIP) Telephone: Home (____) _____ Work (____) _____

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

Spouse/Significant Other: ☐ Alive/Age _____ ☐ Deceased/Age _____ Major Illnesses _____

EDUCATION (circle highest level attended):

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

Occupation _____ Number of hours worked/average per week _____

Referred here by: (check one) ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? ☐ Yes ☐ No If yes, Name: _____

Describe briefly your present symptoms: _____

_____

_____

_____

Date symptoms began (approximate): _____ **Example**

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

_____

_____

_____

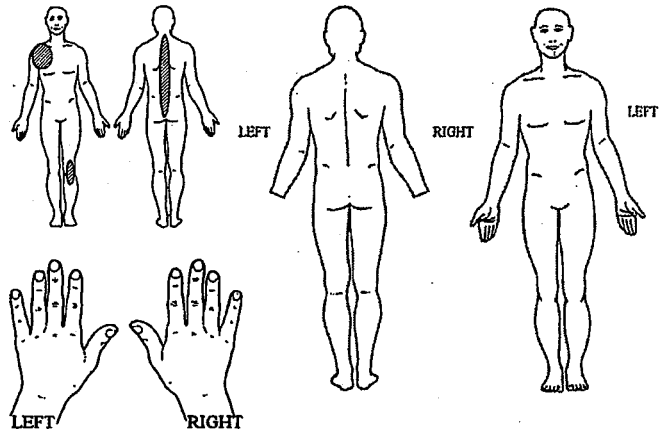
Please list the names of other practitioners you have seen for this problem:

_____

_____

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

Example:



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

Patient's Name _____ Date _____ Physician Initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago?_____

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

Has anyone ever told you to cut down on your drinking?

❑ 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 _____

Amount per week_____

How many hours of 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

Other significant illness (please list) _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

Previous Operations

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes Describe:_____

Any other serious injuries? ❑ No ❑ Yes 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 each _____

Health 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 _____	❑ Goiter _____
❑ Colitis _____	❑ Alcoholism_____	❑ Psoriasis _____	

Patient's Name _____ Date _____ Physician Initials _____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

_____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	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 (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)		❑	❑	❑	
Codeine (Vicodin, Tylenol 3)		❑	❑	❑	
Propoxyphene (Darvon/Darvocet)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		❑	❑	❑	
Gold shots (Myochrysine or Solganol)		❑	❑	❑	
Hydroxychloroquine (Plaquenil)		❑	❑	❑	
Penicillamine (Cuprimine or Depen)		❑	❑	❑	
Methotrexate (Rheumatrex)		❑	❑	❑	
Azathioprine (Imuran)		❑	❑	❑	
Sulfasalazine (Azulfidine)		❑	❑	❑	
Quinacrine (Atabrine)		❑	❑	❑	
Cyclophosphamide (Cytoxan)		❑	❑	❑	
Cyclosporine A (Sandimmune or Neoral)		❑	❑	❑	
Etanercept (Enbrel)		❑	❑	❑	
Infliximab (Remicade)		❑	❑	❑	
Prosorba Column		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient's Name _____ Date _____ Physician Initials _____

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram ____/____/____ Date of last eye exam ____/____/____ Date of last chest x–ray ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- ❑ Recent weight gain
  amount _____
- ❑ Recent weight loss
  amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears–Nose–Mouth–Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing

Cardiovascular

- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began:_____

Periods regular? ❑ Yes ❑ No

How many days apart? _____

Date of last period? ____/____/____/

Date of last pap?____/____/____

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ❑ Morning stiffness
  Lasting how long?
  _____ Minutes _____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient's Name _____ Date _____ Physician Initials _____

PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		❑	❑	❑	
Alendronate (Fosamax)		❑	❑	❑	
Etidronate (Didronel)		❑	❑	❑	
Raloxifene (Evista)		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal (Miacalcin, Calcimar)		❑	❑	❑	
Residronate (Actonel)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid (Benemid)		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol (Zyloprim/Lopurin)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen (Nolvadex)		❑	❑	❑	
Tiludronate (Skelid)		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyalgan/Synvisc injections		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	
Please list supplements:					

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list: _____

_____

_____

_____

_____

Patient's Name _____ Date _____ Physician Initials _____

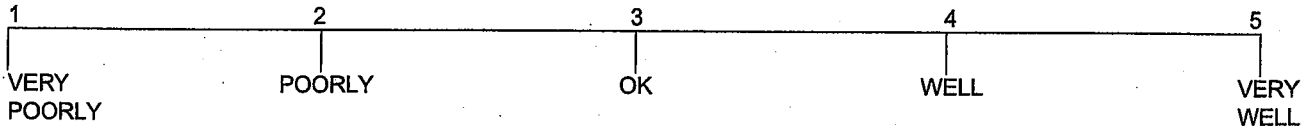
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No If yes, how many? _____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from chair?	❑	❑	❑
Touching your feet while seated?	❑	❑	❑
Reaching behind your back?	❑	❑	❑
Reaching behind your head?	❑	❑	❑
Dressing yourself?	❑	❑	❑
Going to sleep?	❑	❑	❑
Staying asleep due to pain?	❑	❑	❑
Obtaining restful sleep?	❑	❑	❑
Bathing?	❑	❑	❑
Eating?	❑	❑	❑
Working?	❑	❑	❑
Getting along with family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness?	❑	❑	❑
Do you use a cane, crutches, as walker or a wheelchair? (circle one)	❑	❑	❑

What is the hardest thing for you to do? _____

Are you receiving disability?	Yes ❑	No ❑
Are you applying for disability?	Yes ❑	No ❑
Do you have a medically related lawsuit pending?	Yes ❑	No ❑

Patient's Name _____ Date _____ Physician Initials _____

North Texas Joint Care, P.A.
Leyka M. Barbosa, M.D., F.A.C.R.

7777 Forest Lane, Suite C- 502
Dallas, Texas 75230

Telephone: (972) 566-6599
Fax: (972) 566-6611

Patient's Name:_____

DOB:_____

We are now sending prescriptions to your pharmacy via electronic prescriptions. Please list your preferred pharmacy. Thank You

Estamos mandando recetas electronicamente. Por favor de darnos su farmacia preferida.

Pharmacy Info/Información de farmacia

Name/Nombre

_____

Address/Direccion

_____

Number/Numero

_____