Dr. Carolyn Pace, MD
2034 E Southern Ave, Suite P
Tempe AZ 85282
Phone: 480-456-6561 Fax: 480-491-3500

Thank you for making an appointment with our office. We look forward to caring for you! Please read over this form carefully. We ask that you complete the following:

- ☐ **ARRIVE 30 MINUTES PRIOR TO THE TIME OF YOUR APPOINTMENT.** This allows us to process your insurance and co-pay and to prepare your chart prior to your scheduled appointment time. **ARRIVING LATER THAN 30 MINUTES PRIOR PUTS YOU AT RISK OF LOSING YOUR APPOINTMENT.**

- ☐ Carefully and fully complete the papers included in this packet (demographics sheet and the new patient history form).

- ☐ Contact your insurance company to see if you need a referral to see a Specialist.

  - ☐ If you need a referral, please have your Primary Care Doctor fax your referral to us at 480-491-3500 or bring it with you a the time of your appointment. **YOU MAY BE FINANCIALLY RESPONSIBLE FOR THE ENTIRE COST OF THE VISIT IF YOUR INSURANCE PLAN REQUIRES A REFERRAL BUT WE DO NOT HAVE ONE AT THE TIME OF YOUR VISIT.** Please call our office 2 business days prior to your appointment to ensure that your referral has been received by our office.

- ☐ Gather X-Rays, lab results and doctor's notes that are relevant to why you're being seen. **WE PREFER** that your doctor fax information to us but you can bring copies of the information with you at the time of your appointment if necessary.

- ☐ Bring your current insurance cards (primary, secondary and prescription coverage) with you. If your insurance plan changes before your appointment, please call us to verify that Dr. Pace accepts your new insurance plan.

- ☐ Copays and/or deductibles are due at the time of visit. Please be prepared to pay your copay or the insurance contracted amount if your deductible has not been met.

We will make a courtesy reminder call to you 2 business days before your appointment.

*****If you need to cancel your appointment please do so at least 2 business days prior to your appointment date. There will be $50 charge for cancellations with less than 48 hours notice and no-shows of new patient appointment. Because we have so many new patients waiting to be seen you risk not being able to reschedule.*****

Thank you for choosing us for your Rheumatology care. We look forward to serving you!

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 / APT#) 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 work: ________

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: ______________________________

Describe briefly your present symptoms: ______________________________

____
____
____
____

Date symptoms began *(approximate)*: ____________

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:

LEFT RIGHT LEFT

LEFT RIGHT

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: ________

 © 2016 American College of Rheumatology

SYSTEMS REVIEW

As you review the following list, please check any 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 swallowing

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

Respiratory
- ❑ Shortness of breath
- ❑ Difficulty 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: ________

 © 2016 American College of Rheumatology

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 have 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 SURGERIES

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 decreased ______

Number of siblings ______ Number living ______ Number decreased ______ List ages of each ______

Health of children ____________

Do you know 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: ______

 © 2016 American College of Rheumatology

MEDICATIONS

Drug allergies: ❑ No ❑ Yes If yes, please list: ______________________

____

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/Dose	Length of time	Please check: *Helped?*			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past					
Flurbiprofen · Diclofenac + misoprostil · Aspirin (including coated aspirin) · Celecoxib · Sulindac · Oxaprozin · Salsalate · Diflunisal · Piroxicam · Indomethacin · Etodolac · Meclofenamate · Ibuprofen · Fenoprofen · Naproxen · Ketoprofen · Tolmetin · Choline magnesium trisalcylate · Diclofenac					
Pain Relievers					
Acetaminophen		❑	❑	❑	
Codeine		❑	❑	❑	
Propoxyphene		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab		❑	❑	❑	
Golimumab		❑	❑	❑	
Hydroxychloroquine		❑	❑	❑	
Penicillamine		❑	❑	❑	
Methotrexate		❑	❑	❑	
Azathioprine		❑	❑	❑	
Sulfasalazine		❑	❑	❑	
Quinacrine		❑	❑	❑	
Cyclophosphamide		❑	❑	❑	
Cyclosporine A		❑	❑	❑	
Etanercept		❑	❑	❑	
Infliximab		❑	❑	❑	
Tocilizumab		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient's Name: ______________ Date: ______________ Physician Initials: ______________

 © 2016 American College of Rheumatology

PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: *Helped?* A Lot	Some	Not At All	Reactions
Osteoporosis Medications					
Estrogen		☐	☐	☐	
Alendronate		☐	☐	☐	
Etidronate		☐	☐	☐	
Raloxifene		☐	☐	☐	
Fluoride		☐	☐	☐	
Calcitonin injection or nasal		☐	☐	☐	
Risedronate		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Gout Medications					
Probenecid		☐	☐	☐	
Colchicine		☐	☐	☐	
Allopurinol		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Others					
Tamoxifen		☐	☐	☐	
Tiludronate		☐	☐	☐	
Cortisone/Prednisone		☐	☐	☐	
Hyaluronan		☐	☐	☐	
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: __________

 © 2016 American College of Rheumatology

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...*

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

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, walker or 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: ______

 © 2016 American College of Rheumatology

Carolyn Pace, MD

How did you hear about our practice?

Section 1: Patient Demographics — Required Fields are in **BOLD** Print

Patient Name: ____________ **Date of Birth:** ____________ Nickname: ____________

Gender: ____ Female ____ Male **Marital Status:** ____ Married ____ Single ____ Other

Street Address: ____________ **City, State, Zip:** ____________

Home Phone: ____________ **Cell Phone:** ____________

Email: ____________ Patient Social Security: ____________

Employment Status: ____ Full Time ____ Part Time ____ Unemployed ____ Retired ____ Disabled

Employer Name: ____________ **Work Number:** ____________

Student Status: ____ Full-time ____ Part-time ____ Non-Student School Name: ____________

Emergency Contact Person: ____________ **Relationship:** ____________

Address: ____________ Phone: ____________

Pharmacy Name & Cross Streets: ____________

Referring Physician Name and Phone: **Primary Care Physician:**

Section 2: Primary Insurance and Responsible Party Information — Required Fields are in **BOLD** Print

Primary Insurance: ____________

Policy # or Member ID: ____________ **Group ID:** ____________

Effective Date: ____________ Address: ____________

If the patient is NOT the insured on the above listed plan, please provide the following information:

Insured's Name: ____________ **Date of Birth:** ____________ **Gender: M F**

Insured's Social Security: ____________ **Relationship to Patient:** ____________

Home Phone: ____________ **Work Phone:** ____________ **Employer Name:** ____________

Section 3: Secondary Insurance (When Applicable) — Required Fields are in **BOLD** Print

Secondary Insurance: ____________

Policy # or Member ID: ____________ **Group ID:** ____________

Effective Date: ____________ Address: ____________

If the patient is NOT the insured on the above listed plan, please provide the following information:

Insured's Name: ____________ **Date of Birth:** ____________ **Gender: M F**

Insured's Social Security: ____________ **Relationship to Patient:** ____________

Home Phone: ____________ **Work Phone:** ____________ **Employer Name:** ____________

Authorization for Assignment & Release (All patients/guarantors must sign and date this section)

I authorize my insurance benefits to be paid to the office of Carolyn Pace, MD. I authorize my medical information to be released as required to justify medical necessity on billing documents. I understand and agree to be responsible for any elective or non-covered services that may be provided. I understand that I am financially liable for services rendered and that I am responsible for providing all pertinent insurance information to expedite insurance reimbursement; otherwise I will be found financially responsible for anything the insurance does not pay. I agree to pay my required co-pay at the time of service, and agree that if I do not possess current insurance coverage, that I will pay in full for services rendered at the time of service.

Patient/Guarantor Signature ____________ Date ____________

FOR OFFICE USE ONLY Was eligibility performed? ____ Yes ____ No Staff Initials: ____________ Date of 1st Appointment: ____________

Carolyn Pace, MD

Authority to Release Private Health Information

Patient Name:____Date of Birth:________________________

I give Carolyn Pace, MD and staff authority to release medical information regarding my care to the individuals listed below, if unable to contact me. This authority will be in effect for one (1) year. This form does not apply to medical information released to your physician.

Emergency Contact: ______________________________________ **Relationship:**________________________

Phone:______________________________

Medical Information Release:

Please list persons to whom we may release information:

a) May we release information to the Emergency Contact listed above? _____Yes _____No

b) Any additional/different contact persons.

Name:____Relationship to Patient:__________________________
Phone:____

Name:____Relationship to Patient:__________________________
Phone:____

Name:____Relationship to Patient:__________________________
Phone:____

c) ______ No, I do not want my medical information released to anyone other than myself.

Messages (Choose one):

______ Yes, I give my permission to leave messages regarding my (check all that apply):

_____ Test Results _____ Appointments ____ All Other Messages

______ No, do not leave messages (other than asking that you call back our office)

Patient Signature:____ Date:______________________

Witness:____ Date:______________________

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of this **Authority to Release Private Health Information** but could not because:

_____ Individual refused to sign
_____ Communication barrier
_____ Care provided was emergent
_____ Other:

FOR OFFICE USE ONLY Was eligibility performed? _____Yes _____No Staff Initials:__________ Date of 1st Appointment:______________

Carolyn Pace, MD

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS CAREFULLY

In compliance with the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Carolyn Pace, MD, has established privacy policies and procedures relating to the protected health information of our patients. Protected health information is information related to your past, present and future physical or mental health or condition, or payment for such, in which you personally could be identified. HIPPA requires that providers must maintain the privacy practices, and abide by the terms of the privacy notice currently in effect.

If you have any questions about our privacy practices or any of the information contained in this Notice of Privacy Practices for Protected Health Information ("Notice"), or wish to register any complaints related to our privacy practices, you should contact:

Carolyn Pace, MD, 2034 E Southern Ave, Suite P, Tempe AZ 85282 480-456-6561

We will supply a written copy of this notice to any person requesting it, whether or not they are a current patient. All patients will be given a copy of this notice at the time of the first service provided to them following the effective date listed above. This notice will be posted prominently and copies will be made available in our office.

We reserve the right to make changes to our notice and have any new provisions become effective for all protected health information we maintain. If we make any material changes to the uses or disclosures of protected health information, the individual's rights, our legal duties, or other privacy practices stated in this notice, this notice will be revised. The revised notice will be posted prominently in our office, and we will make the revised notice available to anyone who requests a copy.

Your rights as a patient with respect to your protected health information, you (or your personal representative, with legal authorization) have certain rights:

1. To obtain a paper copy of this notice upon request.
2. To revoke your consents or authorizations.
3. To inspect and obtain a copy of the health information that is used to make individual health care decisions about you (so called "designated record sets").
4. To appeal decisions we make regarding denial of access to your records.
5. To request amendments to your health record.
6. To dispute decisions we make regarding denial of amendments to your records.
7. To request restrictions on certain uses and disclosures.
8. To request that confidential communications take place by alternative means or to alternative locations.
9. To obtain an accounting of disclosure.
10. To lodge a complaint with us or with the Secretary of Health and Human Services if you believe there has been a HIPPA violation, without fear of retaliation, coercion, or intimidation.

FOR OFFICE USE ONLY Was eligibility performed? _____Yes _____No Staff Initials:___________ Date of 1st Appointment:______________

Acknowledgement of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 (HIPPA). Under HIPPA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgement that this notice was received.

Therefore, I, ________________________________ (printed name of patient), acknowledge that Carolyn Pace, MD has provided a written copy of its Notice of Privacy Practices for Protected Health Information:

Signature:______________________________________ Date: ____________________

Cancellation Policy Revised 2019

Our office is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at 480-456-6561 by 12:00pm on the business day prior to your appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 12:00pm on Friday. If prior notice is not given, you will be charged $40 for the missed appointment.

Please sign below to consent to these terms.

I, ______________________________________ (printed name of patient), acknowledge that Carolyn Pace, MD has provided a written copy of its Notice of Privacy Practices for Protected Health Information as well as the Cancellation Policy.

Signature: ____ Date:________________

FOR OFFICE USE ONLY Was eligibility performed? _____Yes _____No Staff Initials:__________ Date of 1st Appointment:______________