

Birmingham Rheumatology & Bone Health Clinic

Greg E. Eudy, MD, PC

513 Brookwood Blvd Suite #500

Birmingham, AL, 35209

205-263-0093

Our staff looks forward to caring for your health needs! Here are a few of our policies that will allow us to serve you better:

1) TIME: we want our office to run on time as much as our patients do! We ask for you to arrive on time for your appointment so the wait time is minimal. We request that new patients check in **30 minutes** before their appointment time with the new patient paperwork filled out. If you have not filled out the paperwork you will need to arrive **1 hour** before your appointment time. If you fail to follow these guidelines, we cannot guarantee that you will be able to be seen on the day of your appointment; you may be asked to reschedule.

2) NO SHOWS: Rheumatologists in our area are busy; wait times of 3-4 months for an appointment are very common. Therefore, if you do not keep your appointment or call within 24 hours of your appointment time, you will be charged a **\$25.00 NO SHOW FEE**. We will not make any further appointments until the no show fee is paid. This policy also applies to follow-up appointments. Failure to pay a **NO SHOW** fee in a timely manner will cause your account to be **locked** until the fee is paid. A **LOCKED** account means no appointments can be made and no prescriptions can be refilled or written.

3) CONTACTING OUR OFFICE: We answer the phone Monday through Thursday (exclusive of major Holidays) from **8:30AM-12:00PM** and from **1:00PM to 3:30PM**. Our phones roll every day at 3:30PM. **We are closed on Fridays!** If it is an emergency please contact our answering service. During busy periods you may be placed on a hold since our office personnel often handles multiple phone calls. However, we want to talk to you personally, so please be patient! If you cannot get through, please allow a few minutes and call again.

4) PRESCRIPTION REFILLS: To ensure that you are properly monitored for any medicines Dr. Eudy may prescribe, he will authorize enough prescription refills at the prescribed dosages so that the medications will last until your next scheduled appointment. If you cancel your follow-up appointment or fail to keep it, be advised that Dr. Eudy will only authorize additional refills for your medications **AFTER** seeing you at a follow-up visit. We require a **24 HOUR IN ADVANCE** for all refills.

All patient balances are due when billed. When you receive a billing statement from us please pay the entire balance promptly. If you cannot do so you must contact Joy Caton in our billing office to arrange a payment plan that pays the entire balance due over no more than a 90 day period. If you fail to pay can cause your account to be locked, meaning no appointments or refills. Dr. Eudy is not a Primary Care Physician. And will not be able to see you for PC needs. YOUR PCP treats all health conditions; acute and chronic. Therefore, we do not fill prescriptions unrelated to conditions we treat.

Thank you very much for your understanding. These policies are designed to achieve our goals of providing you with quality care and service while respecting the value of your time and the time of our other patients. Our staff cares about you and your health. We look forward to meeting you and helping you during your time of need.

Sincerely,

Greg E. Eudy, MD and staff
Your appointment date: _____

Your appointment time: _____

Osteoporosis Prevention and Treatment Clinic

Greg E. Eudy, MD PC Juyoung Jackson, NP-C

Name: _____ DOB: ____/____/____

SS#: _____ Age: _____ Sex: F M

Address: _____

Telephone: (Home) _____ (Cell): _____

(Work): _____ Insurance Name: _____

Contract #: _____ Group#: _____

Secondary Insurance name: _____

Contract#: _____ Group#: _____

Name on card(Insured): _____

Spouse SS#: _____ (If spouse is name on the card)

Spouses DOB: ____/____/____

Emergency Contact: _____ Telephone: _____

Marital Status: Never Married Married Divorced Separated
 Widowed

Spouse/Significant other: Alive/Age: _____

Major illnesses: _____

Education(Circle highest level attended): 7 8 9 10 11 12

College: 1 2 3 4 Graduate School: _____

Occupation: _____ # of hours worked per week: _____

Referred here by: Self Family Friend Doctor Other

Name of person making referral: _____

Primary Care Physician: _____

Osteoporosis Prevention and Treatment Clinic

New Patient Information

1) What is your Ethnic Origin?

Caucasian African American Hispanic Asian Other

2) What is your height? _____

3) Have you lot weight? _____

4) Have you lost height? _____

5) Have you had a bone density test prior to this
visit? _____

6) What is the major problem that prompted you to come to the
Osteoporosis Clinic today?

Past Fracture History:

TYPE OF FRACTURE	YES	NO	MONTH	YEAR
Hip fracture				
Vertebral(spine fracture)				
Wrist Fracture				
Pelvic Fracture				
Other type of fracture				
Other type of fracture				

Past Osteoporosis Medication:

Drug name	When and how long?	How often did you take it?
Foxamax(Alendronate)		
<u>Boniva(Ibandronate)</u>		
<u>Actonel(Risedronate)</u>		
<u>Reclast(Zoledronic Acid) infusion</u>		
<u>Prolia (Denosumab)</u>		
<u>Forteo(Teriparatide)</u>		
<u>Evenity(Romosozumab)</u>		

Hormonal Factors

IF YOU ARE A MALE PATIENT: (Please circle one)

- 1) Have you ever had a history of male infertility? Yes No
- 2) Have you ever been told that you have low testosterone? Yes No
- 3) Have you ever had any problems with sexual function (impotence)? Yes No
- 4) Have you ever taken hormone therapy? Yes No

5) How many ounces of cheese per week do you eat? _____

6) How many cups of calcium-fortified orange juice do you drink per week? _____

Dietary Supplements:

1) Do you take calcium supplements? _____

If so, specify which pill you take and the dose? _____

Type of calcium pill	Dose of calcium pill	How many pills do you take per day?
Calcium Carbonate(Oscal, caltrate, tums)		
Calcium citrate (Citracal)		
Calcium lactate		
Calcium gluconate		

2) Do you take a daily multi-vitamin? Yes No

If so, what multi-vitamin do you take and how many pills per day?

3) Do you take any supplemental Vitamin D (besides a multi-vitamin)? Yes No

If so, what is the dose of the Vitamin D pill?

4) How many Vitamin D pills do you take per day? _____

IF YOU ARE A FEMALE PATIENT:

- 1) At what age did you start your menstrual period? _____
- 2) How many times have you been pregnant? _____
- 3) How many children have you had? _____
- 4) What's longest you've gone between menstrual periods?

- 5) Have you gone through menopause? Yes No
If so, how old were you when you went through
menopause? _____
- 6) Did you have your uterus surgically removed? Yes No
If so, when and why? _____
- 7) Did you have your ovaries removed? Yes No
If so, when and why? _____
- 8) When was your last mammogram? _____
If so, was it normal? _____
- 9) When was your last pelvic exam? _____
If so, was it normal? _____
- 10) Who is your Gynecologist? _____

HORMONES:

1) Do you take oral contraceptive pills currently or have you taken them in the past? _____

2) Do you currently take hormone replacement therapy?

If yes, what hormone replacement do you take? (Brand/Dose)

3) If you are not taking hormone replacement therapy currently have you taken it in the past? _____

If yes, why was the hormone replacement therapy stopped?

Corticosteroids:

1) Do you currently take corticosteroids? (Prednisone, Prednisolone, Decadron, Medrol or inhaled steroid)? _____

If yes, what is the name of the steroid do you take?

What is the dose? _____

How long have you taken the steroid? _____

2) If you are not currently taking corticosteroids did you take them in the past?

If yes, what is the name of the steroid you took?

What is the dose? _____

How long did you take the steroid? _____

Anabolic Steroids:

1) Do you currently take anabolic steroids such as testosterone (patches or injection), Decadurabolin? _____

2) If yes, what is the name of the steroid you took?

3) What is the dose? _____

4) How long have you taken the steroid? _____

5) If you are not currently taking anabolic steroids did you take them in the past?

6) If yes what is the name of the steroid you took?

7) What was the dose? _____

8) How long did you take the steroid? _____

Thyroid disease:

1) Have you had thyroid problems? _____

If yes, have you had hyperthyroidism (high thyroid level)?

2) Have you had hypothyroidism? (low thyroid levels) _____

Do you take thyroid replacement currently? _____

If yes, what is the name of the pill that you take?

3) What is the dose of your thyroid pill? _____

4) If you do not take thyroid replacement currently- Did you take it in the past?

Dietary Factors:

1) Did you drink milk growing up? Yes No

2) Are you allergic to milk? Yes No

3) Are you lactose intolerant? Yes No

4) How many cups of milk per week do you drink? _____

Personal Habits:

Smoking:

- 1) Have you smoked at least 100 a cigarettes in your life? Yes No
- 2) Do you smoke now? Yes No

If you currently smoke:

- 1) How many cigarettes or packs per day do you smoke? _____
- 2) For how many years have you smoked? _____

If you smoked in the past:

- How long ago was the las cigarette you smoked? _____
- How many cigarettes or packs per day did you smoke? _____
- For how many years did you smoke? _____

Caffeine Intake:

- 1 Do you consume caffeinated beverages currently? Yes No
- 2 How many caffeinated beverages are consumed per day:

Beverage	How many cups per day?
Caffeinated coffee	
Caffeinated tea	
Caffeinated soft drink	

Alcohol Intake:

- 1 Do you consume alcohol at present? Yes No
- 2 Did you consume alcohol in the past? Yes No
- 3 How many drinks in a week consumed: _____

Beverage	Drinks per week
Wine (5 ounce glass is a drink)	
Beer(12 ounce glass, can or bottle is a drink)	
Hard liquor (1 ounce is a drink)	
Other	

EXERCISE:

1 Do you exercise on a regular basis? Yes No

If yes, what type of exercise? _____

2 For how many minutes do you exercise? _____

Family History:

1 Do you have a family history of Osteoporosis or fractures (hip, spine or wrst)?

Yes No

If yes, what is their relationship to you? _____

Past Medical History:

Condition	Yes	No	Comments
Asthma			
Breast Cancer			
Bone Cancer			
Any other cancer			
Blood cots			
Diabetes Mellitus			
Eating disorder			
Stomach removal(Gastrectomy)			
Kidney Stones			
<u>Lupus-symstemic SLE</u>			
Malabsorption			
Parathyroid gland problems			
Rheumatoid Arthritis			
Renal Failure/Dialysis			
Transplant			
Other			
Other			
Other			

Past Surgical History:

Please list all your past surgies:

Fall History: (circle yes or no)

- 1) I have fallen in the past year: Yes No
- 2) I use or have been advised to use a cane or walker to get around safely?
Yes No
- 3) Sometimes I feel unsteady when I am walking: Yes No
- 4) I steady myself by holding onto furniture when walking at home: Yes No
- 5) I am worried about falling: Yes No
- 6) I need to push with my hands to stand up from a chair: Yes No
- 7) I have some trouble stepping up on a curb: Yes No
- 8) I often have to rush to the toilet: Yes No
- 9) I have lost some feeling in my feet: Yes No
- 10) I take medicine that sometimes makes me feel light-headed or more than usual: Yes No
- 11) I take medicine to help me sleep or improve my mood: Yes No
- 12) I take prescribed pain medication: Yes No
- 13) I often feel sad or depressed: Yes No

Renal Failure:

1) Do you have renal (Kidney) failure? Yes No

If yes, who is your nephrologist?

2) What was the cause of your renal failure? _____

3) Have you ever had a biopsy? _____

4) Have you ever been on or are on peritoneal dialysis? _____

5) Have you ever been on or are on hemodialysis? _____

6) Have you had a renal transplant? _____

Parathyrod Disease:

1) Have you ever had a parathyroidectomy? _____

2) If yes, when was it performed? _____

Bone Biopsy:

1) Have you ever had a bone biopsy? _____

2) If yes, where was it done? _____

3) When was it done? _____

4) Why was it done? _____

HIPAA Release Form-Medical Information Release Form

*Authorization for use of disclosure of protected health information.

*Required by Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164.

NAME: _____ Date of Birth: _____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

SPOUSE: _____

Child(ren): _____

OTHER: _____

OR:

INFORMATION IS NOT TO BE RELEASED TO ANYONE.

The Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call me at preferred phone number: _____

If unable to reach me:

You may leave a detailed message on my voicemail

Please leave a message asking me to return your call

The best time of day to be reached is: _____

Signature of patient or personal representative: _____

Printed name of patient or personal representative: _____

Date: _____

TELEPHONE CONSUMER PROTECTION ACT (TCPA):

ALL PATIENTS MUST HAVE A SIGNED COPY ON FILE...

(Only one copy required – Do not re-sign with each visit)

I, _____ (print name), agree that in order for **Greg E. Eudy, MD PC** to service my account or to collect monies I may owe, **Dr. Greg E. Eudy, and/or his employees and/or agents** may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in wireless charges to me. I also agree that contact may include sending me text messages or emails, using the email address I provide with my account, and/or prerecorded/artificial voice messages and/or use of automatic dialing service, as applicable.

I have read the above disclosure and agree **Greg E. Eudy, MD PC**, its employees and/or agents may contact me as described above.

Signature of responsible party

Date

Map & Directions to Brookwood Medical Center

Effective January 8, 2018, Dr. Eudy's office will move to Suite 500 of Brookwood Medical Plaza [BMP, Medical Office D], located at 513 Brookwood Blvd. in Homewood, Alabama; a suburb of Birmingham. To reach the BMP parking deck follow these instructions:

- From I-65, exit east onto Lakeshore Drive (Ala 149) and continue for about two miles. You have multiple routes to the BMP parking deck from which to choose:
 - Turn right onto US31, continue south on US31 for about a half-mile, then exit right onto the ramp to Brookwood Medical Center Drive, which passes over US 31.
 - Turn left at the first traffic light on Brookwood Medical Center Drive, and follow the access road to the top level of the BMP Parking Deck, or
 - Go to the 2nd traffic light on Brookwood Medical Center Drive, and turn left onto Brookwood Blvd. Continue to the bottom entrance to the BMP parking deck.
 - Or, you may continue on Lakeshore under the US31 overpass and turn right at the first traffic light onto Brookwood Blvd. Continue for about a half-mile to the bottom entrance of the BMP parking deck.
- From US 280, exit to Lakeshore Drive (Ala 149), and drive west on Ala 149 towards US31. Turn left at the stop light just before the US31 overpass. You are on Brookwood Blvd. Continue for about a half-mile to the bottom entrance to the BMP parking deck.
- From US 31, use appropriate northbound or southbound off-ramp to Brookwood Medical Center Drive and then follow routes a. or b. above under (1) to reach BMP parking deck.

Click 'Campus Map' under MAPS drop down to see a view of the Brookwood Campus.

Map of Major Roads accessing Brookwood Medical Center

