

Referred by: _____ Primary Care Physician: _____
 Last Name: _____ First Name: _____ Prefix Mr. Mrs. Miss Ms. Dr.
 Middle Name: _____ Preferred Name: _____
 Date of Birth: ____ / ____ / ____ Age: ____ SSN: ____ - ____ - ____
 Address: _____ City: _____ County: _____ State: ____ Zip: _____
 Email Address: _____ Home # () ____ - ____ Cell # () ____ - ____ Work # () ____ - ____

May we leave a message about appointments or normal test results on the phone numbers you provided? Yes No
 Would you like to receive appointment reminders via text message on your cell phone? Yes No
You consent to receive text messages from us that may contain health information or advice. You are not required to provide consent in order to receive such information or advice from your provider. Standard text messaging rates may apply.

Alternate Contact: If you want us to contact you at an alternate address or telephone number, please provide below:
 Alt. Address: _____ City: _____ State: ____ Zip: _____ Phone: () ____ - ____

Marital Status: Married Single Separated Divorced Widowed Partner Unknown
 Ethnicity: Not Hispanic/Latino Hispanic/Latino Declined to Specify
 Race: White Black/African American Asian American Indian/ Alaska Native
 Native Hawaiian/other Pacific Islander Declined to Specify Other Race
 Birth Sex: Male Female Transgender: Yes No
 Gender Identity: Male Female Female-to-Male Male-to-Female Genderqueer Choose not to disclose Other _____
 Sexual Orientation: Straight/heterosexual Lesbian Gay/homosexual Bi-sexual Choose not to disclose Other _____
 Primary Language: English Spanish French Other: _____
 Student Status: N/A Full-time Part-time Employment Status: N/A Full-time Part-time Employer: _____
 Name of Pharmacy: _____ Address: _____ Phone # () ____ - ____
 Emergency Contact Name: _____ Relationship: _____ Phone # () ____ - ____

Person Financially Responsible For Payment (Guarantor) if different from patient

Last Name: _____ Mr. Mrs. Miss Other: _____ Sex: Male Female
 First Name: _____ Date of Birth: ____ / ____ / ____ Age: ____ SSN: ____ - ____ - ____
 Middle: _____ Relationship to Patient: _____
 Address: _____ City: _____ State: ____ Zip: _____
 Home # () ____ - ____ Cell # () ____ - ____ Work # () ____ - ____
 Email Address of person Financially Responsible for Payment _____

Primary Insurance
 Insurance Company: _____
 Policyholder Name: _____
 Member or Policyholder ID #: _____
 Policyholder Date of Birth: _____
 Insurance Co. Phone #: _____
 Group #: _____
 Relationship to Patient: _____

Secondary Insurance
 Insurance Company: _____
 Policyholder Name: _____
 Member or Policyholder ID #: _____
 Policyholder Date of Birth: _____
 Insurance Co. Phone #: _____
 Group #: _____
 Relationship to Patient: _____

Consent for Treatment, Authorization, Assignment of Benefits, and Referral Release

CONSENT FOR TREATMENT: I consent and authorize Roper St. Francis Physician Partners ("RSFPP") physician or designated qualified assistant to provide me medical treatment and to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the RSFH Notice of Privacy Practices, a copy of which has been made available to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I understand that my medical information, including complete medical records, test results, and billing information, may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all my rights and allow payment to be made directly to RSFPP for all medical or surgical benefits otherwise payable to me under terms of my insurance.

PAYMENT GUARANTEE: I understand and agree that I am responsible for paying all co-payments, co-insurance, deductibles, and non-covered services rendered by RSFPP, including charges for services not covered by my insurance. I consent and authorize RSFPP and third party agents of RSFPP to contact me by telephone at any number associated with me, including a wireless number, and to use a pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep RSFPP informed of changes to my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

This consent for treatment, authorization, assignments of benefits and referral release is valid for one year from date signed.

Print Patient's Name: _____

Patient's Signature: _____

Date: ____ / ____ / ____

Print Legal Guardian's Name: _____

Legal Guardian's Signature: _____

Date: ____ / ____ / ____

Ongoing Communication Regarding Your Healthcare

ONGOING COMMUNICATION: DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITIONS? IF YES, TO WHOM?

By listing an individual and/or entity below, you authorize ALL RSFPP physician offices to release and/or discuss your health information with the individual and/or entity you have listed. You may list specific date range or event.

Beginning date/event to be released: _____ End date/event to be released: _____ Or all healthcare information _____

Authorized Individual or Entity	Phone Number	Relationship	Address
_____	(____) _____	_____	_____
_____	(____) _____	_____	_____

*Any revocation or modification to your authorization regarding an individual or organization must be submitted in writing.

A separate **Authorization to Release Information Form** must be completed to release and/or discuss your health information with any individual(s) and/or entity(s) not listed in the section above.

Authorization is not required for treatment purposes.

To request restrictions of the use of your information, you must complete a separate **Request to Restrictions Form**.

Prescriptions

For your convenience, please list below the individual(s) that you authorize to receive prescriptions from your RSFPP provider(s).

Name of Individual	Phone Number	Relationship	Address
_____	(____) _____	_____	_____
_____	(____) _____	_____	_____

PATIENT INFORMATION

Name: _____ DOB: _____ Sex: *M* *F*

Race: _____ Age: _____ Family MD: _____

Involved body part: _____ Referring MD: _____

Date of injury / onset: _____ Work related: *YES* *NO*

Last full-time work date: _____ Do you need a form to return to work/school: *YES* *NO*

How injury occurred? : _____

Where injury occurred? : _____

Dominant Hand? (circle one): *LEFT-HANDED* *RIGHT-HANDED*

CHIEF COMPLAINT / HPI: (the reason for today's visit):

Location (Example bottom of foot, left hand, etc): _____

Quality (Example: throbbing, numb, etc): _____

Severity (Example: intolerable, dull, sharp, etc): _____

Duration (Example: all day, few minutes, all night, etc): _____

Timing (Example: upon rising, at end of day, etc): _____

Context (Example: while typing, after exercising, etc): _____

Modifying Factors (Example: what improves or worsens symptoms, etc): _____

Associated Signs & Symptoms (Example: tingling, stiffness, etc): _____

KNOWN SIGNIFICANT MEDICAL DIAGNOSES AND CONDITIONS:

Height: _____ Weight: _____

Medical Illnesses (Please check below all that apply):

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Weight Changes | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Instability/Balance Issues | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies/Hay Fever?/Latex | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Swelling | <input type="checkbox"/> Tingling/Numbness |
| <input type="checkbox"/> Change in Vision | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Redness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Temperature Intolerance | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Painful / Stiff Joints | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Change in Activity Level |
| <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Weakness | <input type="checkbox"/> Pain/Cramping after Exertion |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor Wound Healing | <input type="checkbox"/> Limited Range of Motion | On blood thinner? <i>Y</i> or <i>N</i> |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Blood Clots | Take Insulin? <i>Y</i> or <i>N</i> |

Other health complications not listed above: _____

PAST MEDICAL HISTORY:

Known significant medical operative and invasive procedures *(type of surgery and date):*

Family Medical History *(list family illnesses):*

SOCIAL HISTORY:

Do you work outside the home? YES NO If yes, occupation? _____

What physical activities do you do on a regular basis? : _____

Do you smoke? YES NO If yes, how much and how long? _____

Do you consume alcohol? YES NO If yes, how much and how long? _____

ADVERSE AND ALLERGIC DRUG REACTIONS *(list all):*

MEDICATIONS CURRENTLY TAKING *(list all):*

OTHER: Are there other questions or concerns that you have for your Doctor/ provider today?
If so, please list them below:

Are you a resident of a skilled nursing facility? YES NO

If yes, name of facility? _____

Address _____

Effective Dates From: _____ *TO:* _____

PATIENT / GUARDIAN SIGNATURE

DATE



PATIENT INFORMATION – PAIN FORM

This information is required by most insurance carriers when medical services are related to ANY Accident/Injury/Incident.

Patient's Name: _____ Date of Birth: _____

Please indicate reason for visit: (Please note, date **MUST** be MM/DD/YYYY)

Accident/Injury **Date of Injury:** ____/____/____

Where Accident/Injury Occurred:

- Work Related (Give Employment Information Below)
- Auto Accident In what state did accident occur? _____ (required)
- Home
- Other, Please specify: _____

Please give a brief description of Accident/Injury:

Onset of Symptoms/Pain **Approx First Date of Symptoms:** ____/____/____

Please give a brief description of symptoms:

To the best of my knowledge, the information provided above is correct:

Patient Signature: _____ Date: _____

EMPLOYMENT INFORMATION FOR WORK RELATED INJURY

This information is required for all work related injuries when a Worker's Compensation Insurance Carrier should be billed. Please give the staff any paperwork you received from your employer and/or their worker's compensation insurance, so we may file your services properly. WITHOUT the correct billing information for the work related injury, you may be held responsible for payment.

Name of Employer: _____

Name of Employer Contact: _____ Contact Phone #: _____

Work Comp Policy/Claim #: _____

Name/Address of Work Comp Carrier

***If Dept of Labor, Diagnosis Code(s): _____

*Provide Letter from DOL. The DOL should have sent you a letter approving your claim and assigned a diagnosis.

Name of Adjuster: _____ Phone: (_____) _____ - _____