ROPER ST. FRANCIS
PHYSICIAN PARTNERS

PATIENT INFORMATION FORM

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
_____	(____)_____	_____	_____
_____	(____)_____	_____	_____

ROPER ST. FRANCIS
PHYSICIAN PARTNERS

CHART#: _____

DATE: _____

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*):

___Weight Changes
___Allergies/Hay Fever?Latex
___Change in Vision
___Ringing in Ears
___Temperature Intolerance
___Excessive Thirst
___Cold Extremities
___Fatigue
___Edema

___Shortness of Breath
___Wheezing
___Chest Pain
___Dizziness
___Heartburn
___Abnormal Bleeding
___Circulatory Problems
___Poor Wound Healing
___Sleep Apnea

___Instability/Balance Issues
___ Swelling
___Redness
___Muscle Aches
___Painful / Stiff Joints
___Skin Rash
___Weakness
___Limited Range of Motion
___Blood Clots

___Seizures
___Tingling/Numbness
___Depression
___Anxiety
___Headache
___Change in Activity Level
___Pain/Cramping after Exertion
On blood thinner? Y or N
Take Insulin? Y or N

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**

ROPER ST. FRANCIS

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: (_____) _____ - _____