

Name: _____ Date: _____

Age: _____ DOB: _____ Sex: *Male* *Female*

Family MD: _____ Referring MD: _____

CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS

Date of onset of injury/problem: _____
Describe your current orthopaedic problem/ injury: _____

Is your problem/injury related to: *(please check)*
 Auto-accident Work-related accident Other accident Litigation pending

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

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

Severity: Over Past Week (0= none, 10=extreme) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Duration *(Example: intermittent, constant):* _____ Length of Time: _____

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

Context *(Example: improving, worsening, recurrent):* _____

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

Associated Signs & Symptoms *(Example: tingling, stiffness, locking, swelling):* _____

Recent Imaging Studies? Y / N Where? _____

MEDICATIONS

(Please list all long-term medications, current medications, over-the-counter drugs and herbal preparations)

Are you currently taking Coumadin, Plavix, Aspirin, or other blood thinner? YES NO

ADVERSE & ALLERGIC DRUG REACTIONS

<u>Drug</u> (check all that apply)	<u>Reaction</u> (circle all that apply)		
<input type="checkbox"/> None			
<input type="checkbox"/> Penicillin	Rash	Anaphylactic Shock	Other:
<input type="checkbox"/> Sulfa Drugs	Rash	Anaphylactic Shock	Other:
<input type="checkbox"/> Others, please list below:			
_____	Rash	Anaphylactic Shock	Other:
_____	Rash	Anaphylactic Shock	Other:

(Over)

PAST MEDICAL HISTORY

Have you ever or do you currently have any of the following? Please check all that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Stroke | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> GI Disease | <input type="checkbox"/> Seizure/Epilepsy | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart Attack / MI | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Back/Neck Pain |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Staph | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pulmonary Embolus | <input type="checkbox"/> HIV /AIDS | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Bleeding Issues | | |

Other medical problems: _____

Past Surgery/Procedures: (type and dates) _____

Any problem with the following types of anesthesia? (please check)

General IV Sedation Local Dental Anesthesia

If you checked any of the above types of anesthesia, please explain the problem:

FAMILY HISTORY (check any family illnesses)

Diabetes Bleeding problems Blood Clots Anesthesia Problems

Rotator Cuff Tear Other (describe below): _____

SOCIAL HISTORY

Are you working now? YES NO What is your occupation? _____

Single Married Widowed Live Alone Live With Others

Do you smoke tobacco?

- Current Smoker
 Former Smoker
 Non-Smoker

Do you drink alcohol? YES NO How much? _____

History of substance abuse? YES NO If yes, please describe _____

Pregnant or could be pregnant? YES NO

REVIEW OF SYSTEMS

Height: _____ Weight: _____ Blood Pressure: _____

Please circle and describe the symptoms that pertain to you:

- YES NO Constitutional (sleep disturbance, weight loss): _____
YES NO Dermatology (rash): _____
YES NO Endocrine (thyroid problems): _____
YES NO Respiratory (shortness of breath.): _____
YES NO Cardiovascular (swelling, blood clots, dizziness): _____
YES NO Gastrointestinal (GI) (reflux): _____
YES NO Hematologic (bleeding tendency): _____
YES NO Musculoskeletal (arthritis, stiffness, etc.): _____
YES NO Neurological (seizures, weakness, numbness): _____
YES NO Psychiatric (depression, anxiety): _____



Patient eCW Account # _____

Roper St. Francis Physician Partners –
Injury and/or Pain Form

This information is required by most insurance carriers when medical services are related to any accident, injury or incident.

Patient Name: _____ Date of Birth: _____

Date of accident or incident or approximately first date of symptoms: _____

Where did the accident occur? (Must check one of the boxes below)

- Work Related – (see below and give employment information)
- Auto Accident – What state did the accident occur? _____ Currently in litigation? Y/N
- Home
- Other

Please give a brief description of how the accident occurred? Example: Twisted foot/ankle after stepping into a hole in yard at home around 5 pm last Thursday.

Employment Information for Work Related Injury

(If not employment related, please skip down to the signature section below.)

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 employment and/or their worker’s compensation insurer so we may file your services properly. Without the correct billing information for a w/c claim, you may be held responsible for the claim.

Name of Employer: _____ Contact Person: _____

Contact Person Phone: _____ Claim No: _____

Name and Address of W/C Carrier:

Adjuster: _____ Adjuster Phone: _____

To the best of my knowledge, the information provided on this form is correct.

Patient Signature: _____ Date: _____

Patient Name: _____ Age: _____ Occupation _____

Which knee hurts? (circle one) RIGHT LEFT BOTH

Describe in detail the nature of the injury _____

Rate your pain over the last week by putting a circle around the worst pain and a square around the least amount of pain

LOWEST 1 2 3 4 5 6 7 8 9 10 HIGHEST

What makes the pain worse? _____

What makes the pain better? _____

Did you feel a pop when you injured it? (circle one) YES NO

Did your knee swell immediately? (circle one) YES NO

Does it feel stiff if you sit for a long period of time? (circle one) YES NO

Have you had any previous injuries or surgeries to your hip, knee, ankle on this side?
(circle one) YES NO

If yes, describe _____

Does it hurt going up and down the stairs? (circle one) YES NO

Have you previously had any physical therapy for this particular problem? (circle one)
YES NO

If yes, when and where was the therapy performed? _____

Have you previously had injections for this problem? (circle one) YES NO

If yes, when and who did the injections? _____

What medications do you take for this pain? (list all the over-the-counter and
prescription medications and analgesic rubs) _____

What is the most active thing you do with your legs? ie; sports, chores, home repair or
work related activity? _____

Patient Information

Referred by: _____ Primary Care Physician: _____

Last Name: _____ First Name: _____ Mr. Mrs. Miss Other _____

Middle Name: _____ Preferred Name: _____

Date of Birth: ____ / ____ / ____ Age: ____ SSN: ____ - ____ - ____

Address: _____ City: _____ County: _____ State: ____ Zip: _____

Email Address: _____

Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____

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.

Marital Status: Married Single Separated Divorced Widowed Partner Unknown

Ethnicity: Hispanic/Latino Not Hispanic/Latino Other _____

Race: Caucasian African American Asian Other _____

Birth Sex: Male Female

Gender Identity: Male Female Female-to-Male Male-to-Female Genderqueer Choose not to disclose Other

Transgender: Yes No

Sexual Orientation: Lesbian Gay/homosexual Straight/heterosexual 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: _____

Pharmacy Name: _____ Address: _____ Phone: () _____

Emergency Contact Name: _____ Relationship: _____ Phone: () _____

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: () _____

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 Phone: () _____ Cell Phone: () _____ Work Phone: () _____

Financially Responsible Person's Email Address: _____

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 a 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 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, 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
_____	(____) _____	_____	_____
_____	(____) _____	_____	_____