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

Date:________________

HISTORICAL DATA
RSF Physician Partners Orthopaedics – Dr. Aymond

Last Name:________________________ First Name:________________ Middle Init:______

Date of Birth:__________________ Referring Physician:______________________________

1. Age:______
2. Sex: _____Male _____Female
3. Race: Caucasian ☐
   African American ☐
   Asian ☐
   Native Hawaiian/Pacific Islander ☐
   Other:__________________ ☐
4. Marital Status:
   Single / Never Married ☐
   Married ☐
   Divorced / Separated ☐
   Widowed ☐
5. Height: ______feet, ______inches
6. Weight: _________ pounds
7. Job: Heavy manual labor ☐
   Light manual labor ☐
   Non-manual labor ☐
   Not working ☐
8. How long have your worked for your present employer?
   6 months or less ☐
   6 months to 1 year ☐
   1 year to 3 years ☐
   More than 3 years ☐
   Not applicable ☐
9. Are you still working? ____Yes ____No
10. If not still working, how long have you been off work?
    0-3 months ☐
    3-6 months ☐
    6-12 months ☐
    1-2 years ☐
    More than 2 years ☐
11. Have you filed a **FIRST REPORT OF INJURY** with your employer for this injury?
    Yes ☐
    No ☐
    Don't know ☐
12. Do you have an attorney assisting you with this injury/claim?
    Yes ☐
    No ☐
    Don't know ☐
13. How did you injure your back or neck?
    Unknown ☐
    Twisting ☐
    Lifting ☐
    Bending ☐
    Squatting ☐
    Slipping ☐
    Fall from height (______) ☐
    Direct blow ☐
    Other:______________ ☐
14. Did your accident occur at work?
    Yes ☐
    No ☐
    Not certain ☐
    Not applicable ☐

15. How long have you had back pain?
- 0-3 months ☐
- 3-6 months ☐
- 6-12 months ☐
- 1-2 years ☐
- More than 2 years ☐

16. Which term best describes your pain? *(Check all that apply)*
- Constant ☐
- Worse with activities ☐
- Worse with rest ☐
- Worse at night ☐
- Unpredictable ☐
- Intermittent ☐
- No pain ☐

17. Does your pain also occur in…? *(Check all that apply)*
- Buttock ☐
- Thigh ☐
- Calf ☐
- Foot ☐
- Toes ☐
- Not applicable ☐

18. Does the pain involve…?
- Back only ☐
- Back and one lower extremity ☐
- Back and both lower extremities ☐
- Lower extremity only ☐
- Not applicable ☐

19. Have you had any change in urination associated with your pain?
- Yes ☐
- No ☐
- Don't know ☐

20. Aside from your back or neck problem, are you in good general health?
- Yes ☐
- No ☐
- Don't know ☐

21. Do you have, or have you ever had…?
- Cancer ☐
- Diabetes ☐
- High blood pressure (requiring medication) ☐
- Neck pain ☐
- Coronary bypass surgery? ☐

22. Do you exercise…?
- Never ☐
- Less than 20 minutes per week ☐
- 20 to 60 minutes per week ☐
- At least 60 minutes per week ☐
- More than 60 minutes per week ☐

23. How many major surgeries have you had?
- None ☐
- 1-2 ☐
- 2-4 ☐
- 5 or more ☐

24. How many back or neck surgeries have you ever had? ________________

25. Have you ever received a chymopapain or collagenase enzyme for pain?
- Yes ☐
- No ☐
- Don 't know ☐

26. How many visits to doctors or chiropractors have you had in the past year for any reason?
- None ☐
- 1 ☐
- 2-4 ☐
- 4-8 ☐
- 8-12 ☐

27. Check all medications you have taken for your back or neck pain:
- Tylenol (plain) ☐
- Aspirin ☐
- Percodan ☐
- Codeine ☐
- Valium ☐
- Demerol ☐
- Talwin ☐
- Other:____________________ ☐

28. Do you enjoy your job?
- Yes ☐
- No ☐
- Not applicable ☐

29. Do you like your boss?
- Yes ☐
- No ☐
- Not applicable ☐

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:* ____________________

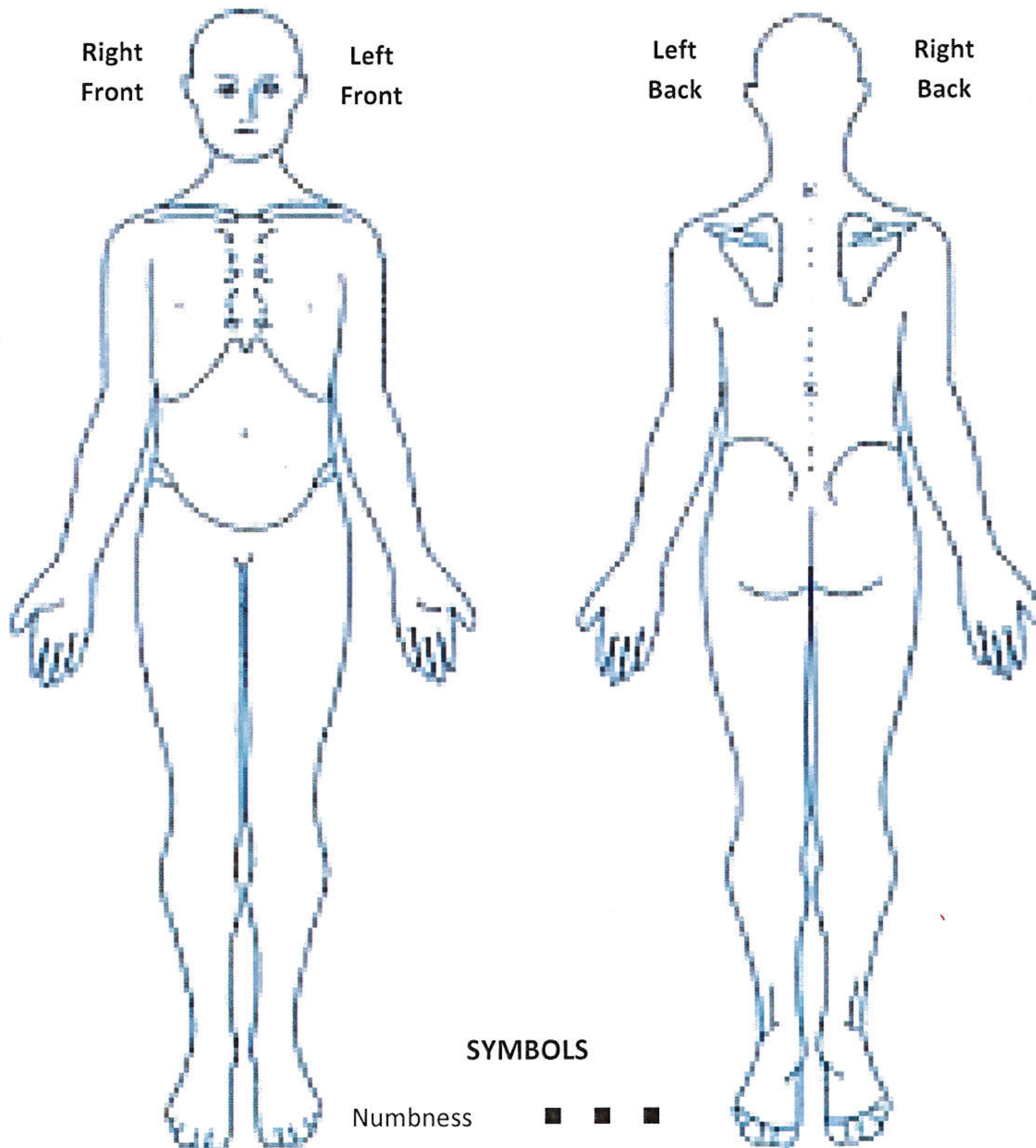
______________________________ ____________________

PATIENT / GUARDIAN SIGNATURE **DATE**

ROPER
ST. FRANCIS
PHYSICIAN PARTNERS

Patient Body Diagram – Dr. Aymond

Mark the areas where you feel the described sensations on your body.
Please use the appropriate symbols
Mark areas of radiation.
Include all affected areas.



SYMBOLS

Numbness	■ ■ ■
Pins & Needles	❍ ❍ ❍
Burning	X X X
Stabbing	II II II

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: (_____) _______ - _________