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 # _____

NEW PATIENT INFORMATION

Joshua Lamb, M.D., Orthopaedics

Name: _____ **Date:** _____

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

Family MD: _____ **Referring MD:** _____

CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS

Date of onset of injury/problem: _____

Please 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 (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, during/after exercise): _____

Context (example: improving, worsening, recurrent): _____

Modifying Factors (example: what improves or worsens symptoms): _____

Associated Signs & Symptoms (example: tingling, stiffness, swelling): _____

Recent Imaging Studies (xray, CT scan, MRI)? Y / N Where? _____

MEDICATIONS: (*Please list all known long-term medications, including current medications, over-the-counter drugs and herbal/vitamin supplements):*

_____ _____

_____ _____

_____ _____

Are you currently taking Coumadin, Plavix, Aspirin, or other blood thinning medications? *YES* *NO*

ADVERSE AND ALLERGIC DRUG REACTIONS:

Drug (check all that apply):	Reaction (circle all that apply):		
None			
Penicillin	Rash	Anaphylactic Shock	Other:
Sulfa	Rash	Anaphylactic Shock	Other:
Others – please list below:			
	Rash	Anaphylactic Shock	Other:
	Rash	Anaphylactic Shock	Other:

PAST MEDICAL HISTORY:

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

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

Other Medical Problems: _____

Past Surgery / Procedures (types and dates): _____

_____

Have you ever had a problem with any of 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
Other, please describe):

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 How much?_____ # of Years?_____
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: _____

Please circle and describe the symptoms that pertain to you:

YES *NO* Constitutional *(fever, weight loss, sleep disturbance etc.):* _____
YES *NO* Heart *(chest pain, murmur, irregular beats, etc.):* _____
YES *NO* Circulation *(high blood pressure):* _____
YES *NO* Respiratory *(asthma, shortness of breath, cough, etc.):* _____
YES *NO* Gastrointestinal (GI) *(appetite, reflux, diarrhea, constipation, etc.):* _____
YES *NO* Musculoskeletal *(arthritis, stiffness, etc.):* _____
YES *NO* Dermatology *(acne, rash, etc.):* _____
YES *NO* Neurological *(seizures, weakness, numbness, balance, etc.):* _____
YES *NO* Psychiatric *(depression, mood liability, other):* _____
YES *NO* Endocrine *(thyroid problem):* _____
YES *NO* Hematologic *(bleeding tendency, anemia):* _____

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: (_____) _____ - _____