ROPER ST. FRANCIS
PHYSICIAN PARTNERS

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 DESIGNATED 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
____________________________	(_____)______________	_________________________	________________________________
____________________________	(_____)______________	_________________________	________________________________

PATIENT NAME:______________________________________ **DATE:**______________

HEIGHT:____________**WEIGHT:**____________**AGE:**________

Who referred you to this office?______________________________

MEDICAL HISTORY

- € My health conditions are:____
  ____
  ____
- € I have NO previous conditions

SURGICAL HISTORY

Date	Type of Surgery	Doctor	Complications

SOCIAL HISTORY

Do you smoke? YES NO How many years?____________ How many packs per day?_____

Did you quit smoking? YES NO

Do you drink alcohol? YES NO How frequently?______How many drinks per occasion?_______

MEDICATIONS

- € I am taking:____
  ____
  ____
- € I am NOT taking any medications

ALLERGIES

- € My allergies are:____
  ____
  ____
- € I have NO allergies

Patient Name: ______________________ Date: ______________

Have you ever been diagnosed or treated for any of the following? Please select response by filling the bubble

	Yes	No
Hearing Loss	○	○
Gout	○	○
Thyroid Disease	○	○
Asthma	○	○
Tuberculosis	○	○
Emphysema	○	○
Cardiac pacemaker/defibrillator	○	○
Heart Problems	○	○
Circulatory Problems	○	○
Chest Pain at Rest	○	○
Irregular Heartbeat	○	○
Stomach Ulcers	○	○
Regular Menses	○	○
Pregnant at Present	○	○
AIDS/HIV	○	○
Hepatitis	○	○
Skin Ulcer	○	○
Kidney Problems	○	○
Seizures	○	○
Stroke	○	○
Depression	○	○
Anxiety	○	○
Cancer	○	○
Arthritis	○	○
Diabetes	○	○
Taking insulin	○	○

For how long

- ○ Less than 6 months
- ○ 6 months
- ○ More than 1 year

Questionnaire For New Knee Patients

Name: ______________________________ Age: _________ Occupation: ____________________________

Which knee hurts? (please circle one) RIGHT LEFT BOTH

Please describe in detail the nature of the injury: ____

____

Date of onset of pain or injury: (GIVE A SPECIFIC DATE, IF POSSIBLE) ____________________________

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 you knee? (please circle one) YES NO

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

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

Have you had any previous injuries or surgeries to your hip, knee, or ankle on this side? (please circle one) yes no if yes, please describe: ____

____

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

Have you had any physical therapy for this problem? (please circle one) YES NO if yes, when and where was it performed?____

Have you previously had injections for this problem? (please circle one) YES NO if yes, when and did it help? ____

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

____

What is the most active thing you do with your legs? (ie: sports, chores, home repair or work related activity) ____

QUESTIONAIRE FOR NEW SHOULDER PATIENTS

NAME: ______________________________ DOB: ______________ DATE: ______________

AGE: ________ OCCUPATION: ________________ ARE YOU: RIGHT or LEFT HANDED (CIRCLE ON)

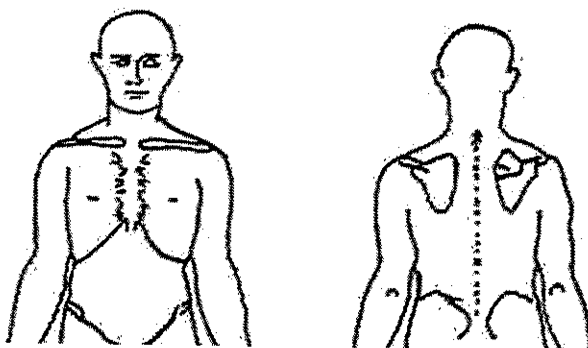
Date of onset of pain or injury: (GIVE A SPECIFIC DATE, IF POSSIBLE) ____________________

If injury, please describe in detail: ____

____

USING THESE ***SYMBOLS*** PLEASE MARK THE AREA ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS.

ACHING ^^^^ ***NUMBNESS*** ==== ***PINS & NEEDLES*** 0000 ***BURNING*** XXXX ***OTHER*** ****



Rate your pain on a scale: (CIRCLE ONE) *LOWEST* 1 2 3 4 5 6 7 8 9 10 *HIGHEST*

What makes your pain worse? ____

What makes your pain better? ____

Do you have pain at night? Please, describe it: ______________________________

____

Do you have neck pain? (CIRCLE ONE) YES OR NO Numbness or tingling in your arms? YES OR NO

Have you had any previous injuries to your shoulder, neck or elbow on this side? YES OR NO

Have you previously had Physical Therapy for this particular problem? YES OR NO

Have you previously had injections for this problem? YES OR NO If yes, when, and did it help?

____

What medications do you take for the pain? (List all over the counter and prescriptions)

____

What is the most active thing you do with your arms, i.e. sports, chores, home, work related activity?

____