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
_____	(_____)_____	_____	_____
_____	(_____)_____	_____	_____

ROPER ST. FRANCIS

Patient Information – Injury/Accident Details

This information is required by most insurance carriers when medical services are related to any Accident/Injury/Incident.

To Be Completed by the Patient/Guarantor:

Patient's Name: _____ **Date of Birth:** _____

Date of Accident, Incident Or Approx. First Date of Symptom(s): _____

Where Accident Occurred:

❒ **Work Related (Enter employment information below)**
❒ **Auto Accident** **State:** _____ **Note: If auto accident, the State in which the accident occurred is required**
❒ **Home**
❒ **Other, Please Specify:** _____

Brief description of how accident/incident or onset of symptoms occurred.

Example: Twisted ankle/foot after stepping in hole in yard at home yesterday at approx. 5pm

_____

_____

_____

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 provide any paperwork you received from your employment and/or their worker's compensation insurance, so we may file your services properly. Without the correct billing information, for a work related injury, you may be held responsible for payment.

Name of Employer: _____

Name of Employer Contact: _____ **Contact Phone:** (_____) _____-_____

Work Comp Policy/Claim #: _____

Name and 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 #** (_____)_____-_____

Name of person providing information: _____ **Relationship to Patient:** _____

To the best of my knowledge, the information provided above is correct.

Patient's Signature: _____ **Date:** _____

Please check Admits or Denies

NAME _____

	Admits	Denies
Allergies/Immunology		
Allergies		
Endocrine		
Gout		
Thyroid problems		
Diabetes		
Respiratory		
Sleep Apnea		
Asthma		
COPD		
Cardiovascular		
Circulatory problems		
Angina		
Coronary Heart Disease		
High Blood Pressure		
Blood clots in lungs		
Gastrointestinal		
GERD		
Musculoskeletal		
Pain at night		
Arthritis		
Arm swelling		
Trauma to arms		
Weakness		
Extremities		
Numbness/Tingling		
Skin		
skin disorders		
Neurologic		
numbness		
tingling		
Stroke		
Loss of strength		
Pain		
Psychiatric		
Depression		
Anxiety		
General		
High Blood Pressure		
Chest pain or tightness		
Irregular heartbeat		
Shortness of breath		
Fatigue		