ROPER ST. FRANCIS
PHYSICIAN PARTNERS

NEW PATIENT INFORMATION

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

	Drug (check all that apply)	**Reaction** (circle all that apply)		
☐	None			
☐	Penicillin	Rash	Anaphylactic Shock	Other:
☐	Sulfa Drugs	Rash	Anaphylactic Shock	Other:
☐	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:

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

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):* _____

ROPER ST. FRANCIS
PHYSICIAN PARTNERS

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)

O Work Related – (see below and give employment information)

O Auto Accident – What state did the accident occur? _____ Currently in litigation? Y/N

O Home

O 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: _____

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
	(____)_____		
	(____)_____		