

CHART#: _____

NEW PATIENT INFORMATION

DATE: _____

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)

- | | | | |
|---|------------------------------------|--|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Depression | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Severe Anxiety | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Allergies/ Hay Fever | <input type="checkbox"/> Gout | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Malignancies |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Anemia | <input type="checkbox"/> Skin Disorders | |

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



Patient Identification

Last Name: _____ Mr. Mrs. Miss SSN: _____ - _____ - _____
 First Name: _____ Other title _____ Date of Birth: ____/____/____
 Middle: _____ (Doctor, General, the III, etc...) Sex: Male ____ Female ____
 Marital Status: Married Single Separated Divorced Widowed Relationship to Guarantor: _____
 Student Status: Full Part N/A School: _____ Phone: () _____
 Employment: Full Part None Employer: _____ Phone: () _____
 Address: (This practice will send all correspondence to this address unless you provide us an alternate address below)
 Street: _____ City: _____ State: _____ Zip: _____
 Phone: () _____ (RSFH will contact you at this number unless you provide us an alternate number below)
 May we leave a general voice message for appointment reminders at this contact phone number? Yes _____ No _____
 May we leave a general voice message for normal test results at this contact phone number? Yes _____ No _____
 In Case of Emergency Contact Name _____
 Relationship _____ Home Phone () _____ Work Phone () _____

Guarantor/Responsible Party (if different from patient)

Last Name: _____ Mr. Mrs. Miss SSN: _____ - _____ - _____
 First Name: _____ Other title _____ Date of Birth: ____/____/____
 Middle: _____ (Doctor, General, the III, etc...) Sex: Male ____ Female ____
 Address: _____ Phone: Home () _____
 City: _____ State: _____ Zip: _____ Phone: Work () _____
 (Complete only if you want the Practice to communicate with you at an address/phone different than you provided above)
 Alternate Address: _____ Alternate Phone: () _____
 City: _____ State: _____ Zip: _____

Primary Insurance

Secondary Insurance

Member/Policyholder (if different from patient)		Member/Policyholder (if different from patient)	
_____	_____	_____	_____
Member/Policyholder ID#	Date of Birth	Member/Policyholder ID#	Date of Birth
_____	_____	_____	_____
Insurance Co. Phone Number	Group #	Insurance Co. Phone Number	Group #
(____) _____	_____	(____) _____	_____
Insurance Co. Address (Street Address/ P.O. Box)		Insurance Co. Address (Street Address/ P.O. Box)	
_____		_____	
City	State	Zip	
_____	_____	_____	_____

Ongoing Communication Regarding Your Healthcare

We may release/discuss your health information with following individuals/organizations for the following dates of service, range of time, or event(s): From (MM/DD/YY) _____ To (MM/DD/YY) _____

Name (Physician, family, etc)	Address	Phone/Fax	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A separate authorization must be completed if the information being release differs between the individuals/organizations listed above.

Authorization, Assignment of Benefits, and Referral Medical Release

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Roper Saint Francis Healthcare for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this form shall be considered as effective and as valid as the original.

I have been provided a copy of the Roper Saint Francis Healthcare Notice of Information Practices.

Signed: _____ Date ____/____/____

Office Use Only:

Referred by: _____

ACCIDENT / INJURY INFORMATION

Are you being seen today as a result of an accident or injury? _____

If YES, please provide the following information. If NO, please sign and date at bottom.

Patient Name: _____

Insurance Co: _____

Subscriber: _____

Subscriber ID#: _____

Subscriber Employer: _____

Please describe the injury and how it occurred:

Date of Injury: _____ Involved body area: _____

Where did injury take place? _____

Did injury occur as a result of an accident that was caused by someone else? _____

If yes, name and address of person at fault: _____

Insurance company of person at fault: _____

Policy number or claim number: _____

Is this injury work-related? _____ If yes, has claim been filed for Workers Compensation? _____

Name of Workers Compensation Insurance Co. _____

SIGNATURE

DATE

PHONE NUMBER