

Rocky Mountain Neurological/Rocky Mountain MS Clinic

Patient Demographic Form

Patient Information

Patient Name		DOB		Gender
Patient Street Address		City	State	Zip
Primary Phone	Type (Circle) Cell Home Work	Secondary Phone	Type (Circle) Cell Home Work	
Email Address			Social Security Number	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Living w/ partner				
Referring Physician	Phone		Fax	
Primary Care Physician	Phone		Fax	

Emergency Contact Information

Name	Relationship	Phone
Name	Relationship	Phone

Authorization to Discuss Health Information

I hereby authorize Rocky Mountain MS Clinic (RMMSC) to discuss the following specific health information with the individuals I designate below: 1) scheduling/appointment information, 2) medical information including symptoms, diagnosis, medications, and treatment plan, 3) laboratory test results, 4) MRI results, and 5) and billing information. I understand that I have the right to revoke my permission at any time, except where RMMSC has already made disclosures in reliance upon this request. The authorization may be revoked at any time by contacting RMMSC in writing. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by HIPAA.

Designee	Relationship	Phone
Designee	Relationship	Phone

Signature of Patient

Effective Date

Insurance Information

Employer		Phone	
(1) Primary Insurance		Phone	
Name of Policy Holder	Relationship	DOB	
ID/Subscriber #	Group #		
(2) Secondary Insurance		Phone	
Name of Policy Holder	Relationship	DOB	
ID/Subscriber #	Group #		
Person Responsible for bill, if not patient			

PAYMENT EXPECTED AT TIME OF SERVICE

I, the undersigned, give permission to release information to 3rd party carriers and do assign all insurance benefits for treatment to be paid directly to the above named provider, and request that this assignment remain on file with my insurance carrier. I certify that a copy of this assignment shall be valid as the original.

By signing below I accept 100% financial responsibility for all charges incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. I recognize that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. Regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past-due accounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have financial responsibility whether such amount(s) are incurred today or after today.

AUTHORIZATION TO RELEASE INFORMATION

I/we hereby authorize the medical provider, named above, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

MS EDUCATIONAL MATERIALS

€ Please check the box if you do not wish to receive educational materials about MS through your email

Signature of Patient

Date

Name: _____
Date of Birth: _____ Today's Date: _____

SYSTEMS REVIEW

As you review the following list, please check any of the problems which apply to you.

GENERAL:

- Recent weight gain
- Recent weight loss
- Fatigue
- Weakness
- Fever
- Sensitive to heat

NERVOUS SYSTEM:

- Headaches
- Dizziness
- Fainting
- Muscle spasm / weakness
- Loss of consciousness
- Numbness of hands and/or feet
- Memory/Trouble concentrating
- Impaired balance
- sharp/burning/or knife like pain

EARS:

- Ringing in ears
- Recent loss of hearing

EYES:

- Pain
- Redness
- Loss of vision
- Double vision
- Blurred vision
- Dryness

NOSE:

- Loss of smell

Daytime Activities:

Employed? Yes No Job Title _____
 Retired? Yes No If so, when? _____
 Other typical daily activities if not employed _____

MOUTH:

- Sores in mouth
- Loss of taste
- Dryness
- Slurred speech

THROAT:

- Hoarseness
- Difficulty swallowing

HEART AND LUNGS:

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- Shortness of breath
- Difficulty in breathing at night
- Swollen legs and/or feet
- High blood pressure
- Wheezing
- Night sweats

STOMACH AND INTESTINES:

- Nausea
- Constipation
- Persistent diarrhea
- Blood in stools
- Heartburn

KIDNEY/URINE/BLADDER

- Difficulty with urination
- Frequent urination
- Getting up at night to urinate
- Sexual difficulties
- Prostate trouble
- Loss of bladder/bowel control

BLOOD:

- Anemia
- Bleeding tendency

SKIN:

- Easy bruising
- Rash
- Hives
- Sun sensitive
- Color changes of hands and _____ /or feet in the cold

MUSCLE/JOINTS/BONES:

- Joint pain
- Muscle tenderness

SLEEP

- snoring
- gasping for air
- teeth grinding

HABITS

Do you drink alcoholic beverages?
 Yes No If yes, how many _____
 Per day? _____ Per week? _____
 Do you smoke? Yes No Past
 Cigarettes per day? _____
 Do you use drugs for reasons that are _____
 Not medical? If so, please list: _____

Do you get enough sleep at night?
 Yes No

Do you drink caffeine?
 Yes No

Name: _____
 Age: _____
 Primary Care Doctor: _____
 Right or Left-Handed: _____

HISTORY OF PRESENT ILLNESS

Briefly describe your present symptoms: _____

_____ Diagnosis given? _____
 Date symptoms began _____
 List other physicians you have seen for this problem (include physical therapy, surgery and injections)

Current medications and dosages _____

Medication Allergies _____

PAST PERSONAL HISTORY

Do you or have you had: (check if "yes")
 _____ Depression/Anxiety _____ High Cholesterol _____ Sleep apnea
 _____ Abnormal Bleeding or Clotting _____ Diabetes _____ Kidney Stones _____ Stomach ulcers
 _____ Anemia _____ Epilepsy _____ Liver disease _____ Stroke
 _____ Asthma _____ Fibromyalgia _____ Migraines _____ Thyroid
 _____ Breast implants _____ Headaches _____ Miscarriages _____
 _____ Cancer _____ Heart problems _____ Optic neuritis _____
 _____ Cataracts _____ High Blood Pressure _____ Psoriasis _____
 _____ Concussions _____

Other significant illness (please list) _____

Previous operations:

Type:	Year	Surgeon	City
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____

Any serious injury? Yes__ No__ Describe _____

FAMILY HISTORY	If Living		If Deceased	
	Age	Health	Age at Death	Cause of death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____

Number of brothers _____ Number of sisters _____ Marital Status _____
 Number of children _____ Number living _____ List ages of each child _____
 Serious illnesses of your siblings and/or children _____

Do you know of any blood relatives who has had or has any of the following?
 Alcoholism _____ High blood pressure _____
 Auto-immune Ds _____ Lupus _____
 Bleeding tendency _____ Migraine _____
 Cancer _____ Multiple Sclerosis _____
 Colitis _____ Rheumatoid arthritis _____
 Dementia _____ Stroke _____
 Diabetes _____ Thyroid _____
 Epilepsy _____

Name: _____

Date of Birth: _____

Date: _____

Provider: _____

SYSTEMS REVIEW

Review the following list, please check any of the problems which you have had in the last 30 days

NERVOUS SYSTEM:

- No significant abnormalities
- Headaches
- Migraines
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Numbness in hands or feet
- Memory or trouble concentrating
- Impaired balance
- Nerve pain - knife-like
- Nerve pain - burning
- Nerve pain - sharp

EARS, EYES, AND NOSE:

- No significant abnormalities
- Ringing in ears
- Loss of hearing
- Eye pain
- Eye redness
- Loss of vision
- Double vision
- Blurred vision
- Eye dryness
- Loss of smell

MOUTH AND THROAT:

- No significant abnormalities
- Sores in mouth
- Loss of taste
- Dryness of mouth
- Slurred speech
- Hoarseness
- Difficulty swallowing

CIRCULATORY SYSTEM:

- No significant abnormalities
- Chest pain
- Irregular heart beat
- Sudden changes in heart beat
- Swollen legs or feet
- High blood pressure
- Night sweats

RESPIRATORY SYSTEM:

- No significant abnormalities
- Shortness of breath
- Difficulty breathing at night
- Wheezing

DIGESTIVE SYSTEM:

- No significant abnormalities
- Nausea
- Constipation
- Persistent diarrhea
- Blood in stools
- Heartburn

URINARY SYSTEM:

- No significant abnormalities
- Difficulty with urination
- Frequent urination
- Loss of bladder or bowel control

INTEGUMENTARY SYSTEM:

- No significant abnormalities
- Easy bruising
- Rashes
- Hives
- Sun sensitivity
- Color changes of extremities in cold

SKELETAL AND MUSCULAR SYSTEMS:

- No significant abnormalities
- Joint pain
- Tenderness
- Body aches

OTHER FINDINGS:

- Recent weight gain
- Recent weight loss
- Fatigue
- Fever
- Sensitivity to heat
- Sexual difficulties
- Prostate trouble

Do you take medication for your pain?

Yes, please list: _____

No

Rocky Mountain Neurological & MS Clinic

Restroom Policy for Patients in Wheelchairs and Patients Using a Walker with an IV Pole

Our primary concern is your safety. Therefore, all patients of Rocky Mountain Neurological & MS Clinic using wheelchairs must utilize the public restrooms located in the lobby on the 1st floor across from the elevators. The restrooms in the lobby meet ADA guidelines that accommodate patients using wheelchairs and other specialized equipment. The staff of the Rocky Mountain Neurological & MS Clinic is available to accompany patients who request assistance accessing these restrooms.

Printed Name

Date of Birth

Patient Signature

Date

NOTIFICATION AND ACKNOWLEDGEMENT OF
NOTICE OF PRIVACY PRACTICES
REGARDING PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides detailed information about how we may use and disclose Protected Health Information (PHI) about you. Copies of the notice are available for review in our waiting room. As a patient you have a right to your own paper copy of the Notice which you may request from our office.

Rocky Mountain Neurological Associates
370 East 9th Avenue, Suite 106
Salt Lake City, Utah 84103
Phone: 801-408-5700
Fax: 801-408-5704

We reserve the right to change the Notice, and if we do, you may obtain a copy of the revised Notice from the location noted above.

Please acknowledge your receipt of the notification by signing below and returning it to our office.

Patient Signature _____ Date _____

Patient Name (Printed) _____