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 € Single € Married € Divorced € Separated € Widowed € 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

ROCKY MOUNTAIN MS CLINIC

05APR2012

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

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 ___

Daytime Activities:
Employed? Yes____ No____ Job Title _____
Retired? Yes____ No____ If so, when? _____
Other typical daily activities if not employed _____
_____
_____

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")

____ Abnormal Bleeding or Clotting
____ Anemia
____ Asthma
____ Breast implants
____ Cancer
____ Cataracts
____ Concussions
____ Depression/Anxiety
____ Diabetes
____ Epilepsy
____ Fibromyalgia
____ Headaches
____ Heart problems
____ High Blood Pressure
____ High Cholesterol
____ Kidney Stones
____ Liver disease
____ Migraines
____ Miscarriages
____ Optic neuritis
____ Psoriasis
___ Sleep apnea
___ Stomach ulcers
___ Stroke
___ Thyroid

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 t

Alcoholism _____
Auto-immune Ds _____
Bleeding tendency _____
Cancer _____
Colitis _____
Dementia _____
Diabetes _____
Epilepsy _____
Heart disease _____
High blood pressure _____
Lupus _____
Migraine _____
Multiple Sclerosis _____
Rheumatoid arthritis _____
Stroke _____
Thyroid _____

CURRENT MEDICATION LIST

Patient Name / Date of Birth: _____ Date: _____

Please list all medications including supplements and over the counter medications from all doctors

Medication name	Dose (mg, mcg)	Frequency

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

NAME:_____

HEADACHE QUESTIONNAIRE

1. My headaches started on:

2. I get headaches about every : day _____ days a week _____days a month

3. headache is accompanied by (circle): light sesitivity noise sensitivity nausea vomiting dizziness numbness weakness red tearing eye congestion visual changes confusion loss of consciousness neck stiffness

Preventative medications/ medications taken on daily basis to prevent the headache:

Medication	Max dose and duration used, side effects	Did it help?
_ Beta blockers (propranolol, inderol, metoprolol, etc)		
_ Verapamil		
_Amitriptyline (Elavil)		
_Nortriptyline (Pamelor)		
_Depakote (Valproic Acid)		
_Topomax		
_Lyrica		
_Magnesium		
_Butterburr		

Abortive medications / taken to get rid of a headache

Medication	Max dose and duration used, side effects	Did it help?
Tylenol		
Advil		
Excedrin Migraine		
Aleve /Naproxen		
Midrin / Epidrin		
Cafergot		

Fioricet / Fiorinal		
DHE/Migranal		
Triptans: (circle) Maxalt, Imitrex, Relpax, Amerge, Axert, Frova, Zomig		
Narcotics: Percocet, Vicodin, Lortab, Fentanyl..		
Steroids		

Have you tried any of these preventative procedures?

Procedure	How long used?	Did it help?
Botox injections		
Trigger point injections		
Chiropractic manipulation		
Physical therapy		
Acupuncture		

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

1st version 3/7/2012

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)