

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) 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

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: _____

Age: _____

Today's date: _____

Primary Care Doctor: _____

New Patient 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

NERVOUS SYSTEM:

- Headaches
- Dizziness
- Fainting
- Muscle spasms / weakness
- Loss of consciousness
- Numbness of hands and/or feet
- Memory / trouble concentrating
- Impaired balance
- Sharp/Burning/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
 Retired? Yes No

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

Job title: _____
If so, when? _____

BLOOD:

- Anemia
- Bleeding tendency

SKIN:

- Easy bruising
- Rash
- Hives
- Sun sensitivity
- Color changes of extremities 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

If yes, 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

Rocky Mountain MS Clinic/ Dr. Robert M. Miska, LLC

Name: _____
 Date of birth: _____
 Primary Care Doctor: _____
 Right or Left-handed: _____

HISTORY OF PRESENT ILLNESS

Briefly Describe your present symptoms: _____

Date symptoms began: _____ Diagnosis Given?: _____

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")

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Abnormal bleeding or clotting | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast implants | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Migraines | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Miscarriages | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Optic Neuritis | |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Psoriasis | |

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	Cause of Death
Father			Father		
Mother			Mother		
Number of brothers _____		Number of sisters _____		Marital Status _____	
Number of Children _____		Number of 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: (check and give relationship)

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Auto-immune Ds | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Rheumatoid |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid problems |

HEADACHE QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Date: _____

1. My headaches started on: _____
2. I get headaches about every: _____ day _____ days a week _____ days a month
3. My headache is accompanied by:

- | | | |
|--|--|--|
| <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Visual changes | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Noise sensitivity | <input type="checkbox"/> Numbness | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Weakness | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Red tearing eye | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Congestion | |

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, meroprolol, etc)		
Verapamil		
Amitriptyline (Elavil)		
Nortriptyline (Pamelor)		
Depakote (Valproic Acid)		
Topomax		
Lyrica		
Magnesium		
Butterburr		

Abortive medications / taken to get rid of 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: (circle) Percocet, Vicodine, 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		

John F. Foley, MD
Ronald S. Murray, MD
Viktoria Kaplan, MD

Cortnee Roman, FNP-C
Katrina Bawden, FNP-C

Robert M. Miska, MD

Restroom Policy

(For patients in wheelchairs, using a walker and patients with an IV pole)

Our primary concern is your safety. Therefore, all patients of Rocky Mountain MS Clinic & Dr. Robert M. Miska, LLC 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. Our staff is available to accompany patients who request assistance accessing these restrooms.

Patient Signature

Date

Patient Name (Printed)

John F. Foley, MD
Ronald S. Murray, MD
Viktoria Kaplan, MD

Cortnee Roman, FNP-C
Katrina Bawden, FNP-C

Robert M. Miska, MD

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 Multiple Sclerosis Clinic/ Dr. Robert M. Miska, LLC
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)

John F. Foley, MD

Viktorina Kaplan, MD

Robert M. Miska, MD

Ronald S. Murray, MD

Cortnee Roman, FNP-C

Katrina Bawden, FNP-C

**370 East 9th Avenue
Salt Lake City, UT 84103
Suite 106, 111 and 208**

Directions to our office

From the North: On I-15 turn left (east) at the 600 North exit, turn right (south) on 300 West, turn left (east) on North Temple, follow North Temple until it joins 2nd Avenue, turn left (north) on B street, turn right (east) on 9th Avenue, turn left (south) into the parking lot. Our office is on the corner of D street and 9th Avenue, It's a brown brick building labeled 2 Medical Plaza.

From the South: on I-15 take exit 600 South exit, turn left (north) on State Street, turn right (east) on South Temple, turn left (north) on E street, turn left (west) on 9th Avenue, turn left (south) into the parking lot, our office is on the corner of D Street and 9th Avenue, it's a brown brick building labeled 2 Medical Plaza.

