Office of John Foley, MD/ Viktoria Kaplan, MD/ Ronald Murray, MD/ Robert Miska, MD/

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

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) 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**

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

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 spams / weakness
_____ Loss of conciousness
_____ 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

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
_____ Persistant 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 sensitivity
_____ Color changes of extremeties 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

Daytime Activities:
Employed? _____ Yes _____ No Job title: _____
Retired? _____ Yes _____ No If so, when? _____
Other typical daily activities if not employed? _____

_____

_____

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 (inlude 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	____ Depression/Anxiety	____ High cholesterol	____ Sleep apnea
____ Anemia	____ Diabetes	____ Kidney Stones	____ Stomach ulcers
____ Asthma	____ Epilepsy	____ Liver Disease	____ Stroke
____ Breast implants	____ Fibromyalgia	____ Migraines	____ Thyroid problems
____ Cancer	____ Headaches	____ Miscarriages	
____ Cataracts	____ Heart problems	____ Optic Neuritis	
____ Concussions	____ High blood pressure	____ 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	Age	Health
Father		
Mother		

If Deceased	Age	Cause of Death
Father		
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)

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

Please complete **ONLY** if you have a known or possible diagnosis of Multiple Sclerosis

Name: _____ Date of Birth: _____

Date: _____

Patient Questionnaire

How many flare-ups of symptoms/exacerbations have you had in the last year? _____

Are you currently on an MS therapy drug? _____ Which one? _____

Symptom Profile - Please rate average symptoms over the last 30 days
Please only check one box for each symptom.

Fatigue	None ☐	Mild ☐	Moderate ☐	Severe ☐
Depression	None ☐	Mild ☐	Moderate ☐	Severe ☐
Anxiety	None ☐	Mild ☐	Moderate ☐	Severe ☐
Muscle Weakness	None ☐	Mild ☐	Moderate ☐	Severe ☐
Muscle Spasms	None ☐	Mild ☐	Moderate ☐	Severe ☐
Dizziness	None ☐	Mild ☐	Moderate ☐	Severe ☐
Numbness	None ☐	Mild ☐	Moderate ☐	Severe ☐
Memory/Thought Process	None ☐	Mild ☐	Moderate ☐	Severe ☐
Imbalance	None ☐	Mild ☐	Moderate ☐	Severe ☐
Pain	None ☐	Mild ☐	Moderate ☐	Severe ☐
Loss of Vision	None ☐	Mild ☐	Moderate ☐	Severe ☐
Double Vision	None ☐	Mild ☐	Moderate ☐	Severe ☐
Blurred Vision	None ☐	Mild ☐	Moderate ☐	Severe ☐
Difficulty Swallowing	None ☐	Mild ☐	Moderate ☐	Severe ☐
Slurred Speech	None ☐	Mild ☐	Moderate ☐	Severe ☐
Bladder Dysfunction	None ☐	Mild ☐	Moderate ☐	Severe ☐
Bowel Dysfunction	None ☐	Mild ☐	Moderate ☐	Severe ☐
Sexual Dysfunction	None ☐	Mild ☐	Moderate ☐	Severe ☐
Heat Sensitivity	None ☐	Mild ☐	Moderate ☐	Severe ☐

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 (1 pill once a day..etc)

Rocky Mountain Multiple Sclerosis Clinic

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Katrina Bawden, FNP-C

Dr. Robert M. Miska, LLC

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)

Rocky Mountain Multiple Sclerosis Clinic

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Dr. Robert M. Miska, LLC

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)

Rocky Mountain Multiple Sclerosis Clinic **Dr. Robert M. Miska, LLC**

John F. Foley, MD Viktoria 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.