ROCKY MOUNTAIN MS CLINIC DR. ROBERT M. MISKA, LLC

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

Name: ____________________
Age: ____________________
Today's Date: ____________________
Primary Care Doctor: ____________________
Right or left-handed: ____________________

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

BLOOD:
____ Anemia
____ Bleeding tendency

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

EYES:
____ Pain
____ Redness
____ Loss of vision
____ Double vision
____ Blurred vision
____ Dryness

STOMACH AND INTESTINES:
____ Nausea
____ Constipation
____ Persistent diarrhea
____ Blood in stools
____ Heartburn

MUSCLE/JOINTS/BONES:
____ Joint Pain
____ Muscle Tenderness

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

SKIN:
____ Easy bruising
____ Rash
____ Hives
____ Sun sensitive
____ Color changes of hands and /or feet in the cold

MOUTH:
____ Sores in mouth
____ Loss of taste
____ Dryness
____ Slurred speech

NOSE:
____ Loss of smell

THROAT:
____ Hoarseness
____ Difficulty swallowing

EARS:
____ Ringing in ears
____ Recent loss of hearing

SLEEP
____ Snoring
____ Gasping for air
____ Teeth grinding

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

HABITS	(circle)			Amount
Do you drink alcoholic beverages?	No	Yes		Per day? ______ Per week? ______
Do you smoke?	No	Yes	Former	Per day? ______
Do you use marijuana?	No	Yes		

Do you use drugs for reasons that are not medical? If yes, please list: ____________________

____

DAYTIME ACTIVITIES

Employed? No Yes, Job Title ____________________
Retired? Yes, When? ____________________
Other typical daily activities if not employed: ____________________

____

____

Name: ______________________
Today's Date: ______________________

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): ______________

Medication Allergies: ______________________

PAST PERSONAL HISTORY

Do you or have you had: (check if “yes”)

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

Other significant illness (list): ______________________

Date of last mammogram (if applicable): ______________ Date of last pap smear (if applicable): ______________

Date of last skin check: ______________

Previous surgeries/operations	Year

Vaccination Status?		Date	Brand
COVID-19	Y N		
Shingles	Y N		N/A
Hepatitis B	Y N		N/A

Any serious injury? No Yes, describe: ______________________

FAMILY HISTORY

Living?		If yes, overall health?	If no, age at death?	Cause of death?
Father	Y N			
Mother	Y N			

Number of siblings: ______________ Marital Status: ______________

Number of children: ______________ Ages of each child: ______________

Blood relatives with the following conditions: (check and give relationship)

____ Alcoholism	______________	____ Heart disease	______________
____ **Auto-immune Disorders**	______________	____ High blood pressure	______________
____ Bleeding tendency	______________	____ Lupus	______________
____ Cancer	______________	____ Migraine	______________
____ Dementia	______________	____ Multiple sclerosis	______________
____ Diabetes	______________	____ Neurological Problems	______________
____ Epilepsy	______________	____ Stroke	______________
____ Heart disease		____ Thyroid Problems	______________

Other significant illness in family members, including children (list illness & relationship): ______________

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.

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

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
Birth Control Method: ____________________	________________________	______________________________
_____________________________________	________________________	______________________________
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Rocky Mountain MS Clinic

Dr. Robert Miska, LLC

Restroom Policy

(must be completed by all patients)

Our primary concern is your safety. Therefore, all patients of Rocky Mountain MS Clinic and Dr. Robert Miska LLC, using wheelchairs, walkers, or IV poles must utilize the public restrooms located in the lobby on the first floor across from the elevators. These restrooms meet ADA guidelines which accommodate patients using this equipment. Our staff is available to accompany patients who request assistance.

____

Patient Name (Print)

____

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 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.

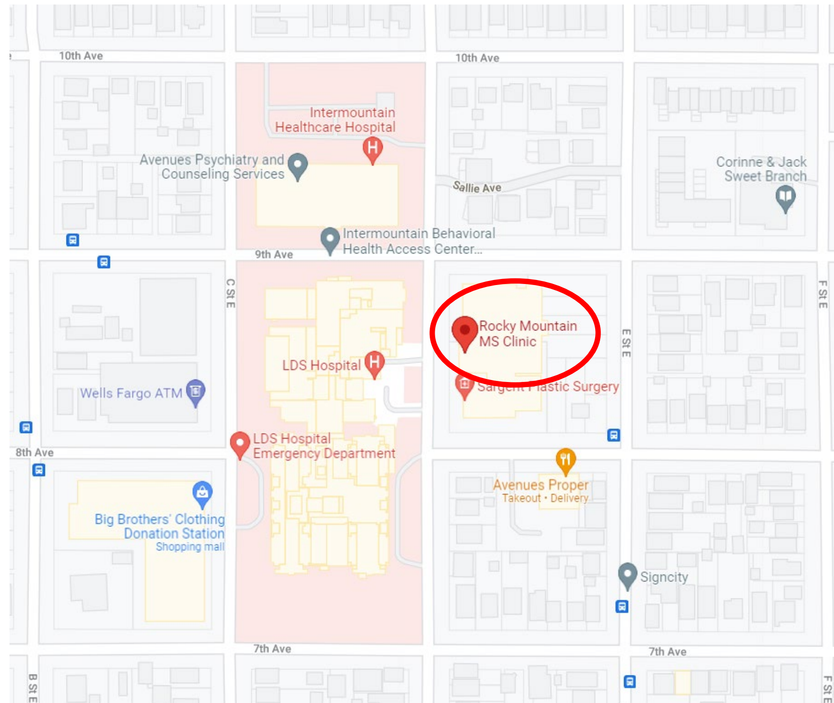
____
Patient Name (Printed)

____
Patient Signature Date

Directions to the Office

The clinic is located in Medical Plaza Building 2 on the LDS Hospital Campus. The infusion center is located on the second floor Suite 208.

370 E 9th Avenue
Suite 106, 111, 208
Salt Lake City, UT 84103



Parking:

Two hour parking on street parking is available on the 9th Avenue in front of the clinic. Minimal parking for the Main Level 1 parking is available from an entrance on 9th Avenue. Additional parking on the B Level is available from an entrance on D street using the upward sloping ramp (see photo). Elevators are available from both parking lots.