

## 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	
<b>Marital Status</b> <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

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**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 3<sup>rd</sup> 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

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**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

## HABITS

- Do you drink alcoholic beverages?
- Do you smoke?
- Do you use marijuana?

## 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

(circle)

- No Yes
- No Yes Former
- No Yes

## 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

Amount  
Per day? \_\_\_\_\_ Per week? \_\_\_\_\_  
Per day? \_\_\_\_\_

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")

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Abnormal Bleeding or Clotting | <input type="checkbox"/> Concussions    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteopenia     |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Depression     | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Osteoporosis   |
| <input type="checkbox"/> Anxiety                       | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Kidney Stones       | <input type="checkbox"/> Psoriasis      |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Sleep apnea    |
| <input type="checkbox"/> Breast implants               | <input type="checkbox"/> Fibromyalgia   | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Miscarriages        | <input type="checkbox"/> Stroke         |
| <input type="checkbox"/> Cataracts                     | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Optic neuritis      | <input type="checkbox"/> 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)

- |   |       |  |       |
|---|-------|--|-------|
| <input type="checkbox"/> Alcoholism                   | _____ | <input type="checkbox"/> Heart disease         | _____ |
| <input type="checkbox"/> <b>Auto-immune Disorders</b> | _____ | <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"/> Dementia                     | _____ | <input type="checkbox"/> Multiple sclerosis    | _____ |
| <input type="checkbox"/> Diabetes                     | _____ | <input type="checkbox"/> Neurological Problems | _____ |
| <input type="checkbox"/> Epilepsy                     | _____ | <input type="checkbox"/> Stroke                | _____ |
| <input type="checkbox"/> Heart disease                | _____ | <input type="checkbox"/> Thyroid Problems      | _____ |

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



**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.

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Patient Name (Print)

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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 9<sup>th</sup> 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.

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Patient Name (Printed)

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Patient Signature

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Date