RIVERVIEW HEALTH PHYSICIANS

PATIENT INFORMATION

PATIENT NAME: PREFERRED (NICK) NAME: SEX:

BIRTH DATE: SOCIAL SECURITY #: PRIMARY CARE PHYSICIAN:

ADDRESS: CITY:

COUNTY: STATE: ZIP:

HOME PHONE: ( ) Circle One: Preferred WORK: ( ) Preferred CELL: ( ) Preferred

PREFERRED LANGUAGE: INTERPRETER NEEDED: Yes No (Circle One)

MARITAL STATUS: Married-Single-Widowed-Divorced-Minor (Circle One) SPOUSE NAME & PHONE:

RACE: Caucasian - African American - Hispanic - Asian - American Indian - Other (Circle One) ETHNICITY: Hispanic Non-Hispanic (Circle One)

PREFERRED METHOD OF CONTACT: Phone - Postal Mail - My Chart (Circle One: Preferred) E-MAIL:

EMPLOYER: EMPLOYMENT STATUS: Full-time Part-time Retired (Circle One)

RESPONSIBLE PARTY DEMOGRAPHICS - PLEASE INDICATE IF SAME AS ABOVE AND DON'T DUPLICATE INFO.

RESPONSIBLE PARTY NAME: RELATION TO PATIENT:

ADDRESS: CITY:

COUNTY: STATE: ZIP:

SOCIAL SECURITY: SEX:

HOME PHONE: ( ) WORK: ( ) CELL: ( )

EMPLOYER: EMPLOYMENT STATUS: Full-time Part-time Retired (Circle One)

SUBSCRIBER DEMOGRAPHICS - PLEASE INDICATE IF SAME AS ABOVE AND DON'T DUPLICATE INFORMATION

SUBSCRIBER NAME: RELATION TO PATIENT:

ADDRESS:

CITY: STATE: ZIP:

EMPLOYER: EMPLOYMENT STATUS: Full-time Part-time Retired (Circle One)

PARENT/GUARDIAN/FAMILY INFORMATION (Complete for minor patients only)

MOTHER'S NAME:

HOME PHONE: ( ) Circle One: Preferred WORK: ( ) Preferred CELL: ( ) Preferred

FATHER'S NAME:

HOME PHONE: ( ) Circle One: Preferred WORK: ( ) Preferred CELL: ( ) Preferred

PATIENT'S PRIMARY RESIDENCE: (Circle One) Mother Father Both Other:

SIBLINGS: NAME: AGE: SEX:

NAME: AGE: SEX:

NAME: AGE: SEX:

UNINSURED

I do not have insurance and understand that I am financially responsible for the charges incurred.

Patient/Guardian Signature: Date:

WORKER'S COMPENSATION INSURANCE (If Applicable)

If your visit is related to a work injury please notify the receptionist and provide your employer information.

SIGNATURE OF INDIVIDUAL COMPLETING FORM

Signature: Date:

Patient History Form

Patient Name:		Marital Status: S_____ M _____ D_____ W _____	
DOB: / /	SSN:	Age:	Gender: M_____ F_____ N A_____
Name of person/physician making referral:			
Primary Care Physician/Family Doctor:			
Body Part: Right Left Both		Acute Injury(New): Yes _____ No _____	
Please describe reason for visit and any symptoms:			
On a scale of 1-10, circle the number that best describes your pain. Least 0 1 2 3 4 5 6 7 8 9 10 Severe			
Approximate date symptoms began or date of injury:			
Resulting from: Sports _____ Accident _____ Work Related _____ Involving Litigation _____			
Are Symptoms: Constant _____ Intermittent _____ Worsening _____ Improving _____			
Check All That Apply: Pain____ Stiffness____ Swelling____ Instability ____ Weakness ____ Numbness/Tingling ____			
What makes symptoms worse?			
What makes symptoms better?			
What previous formal treatment have you had on this body part?(Medications, therapy, surgery, injections)			
Were treatments helpful to any degree? If so, what?			
Past Surgical History and/or Hospitalization			
Previous: Type of operation or reason for hospitalization			
1.			
2.			
3.			
4.			
Any previous fractures? Yes _____ No _____		Any other serious injuries? Yes _____ No _____	
Medication Information			
Do you have any drug allergies? Yes _____ No ____		Are you allergic to latex? Yes _____ No _____	
If yes, name the drug and type of reaction (i.e. rash, nausea, etc.) PLEASE BE SPECIFIC			

Current Medications: (List any you are taking at this time. This includes items such as aspirin, vitamins, laxatives, calcium, etc.)

Name of Drug	Dose/Strength	Number of Pills	How long have you taken?

OVER →

RHP COMMUNICATION OF PRIVATE HEALTH INFORMATION AUTHORIZATION

Patient Name:_____ **DOB:**_____

Please √ and fill out all that are acceptable forms of communication to provide quality patient care.

☐ I authorize the staff of Riverview Health Physicians to leave a message regarding my Private Health Information on my home voicemail or answering machine.

☐ I authorize the staff of Riverview Health Physicians to leave a message regarding my Private Health Information on my cell phone voicemail.

☐ I authorize the staff of Riverview Health Physicians to leave a message regarding my Private Health Information on my work voicemail or answering machine.

☐ I authorize the staff of Riverview Health Physicians to mail written communication to my home address.

☐ I authorize the staff of Riverview Health Physicians to speak with the following individuals to discuss Medical and/or Financial information.

Medical:

Name _____ Phone Number _____ Relationship to Patient _____

Name _____ Phone Number _____ Relationship to Patient _____

Financial:

Name _____ Phone Number _____ Relationship to Patient _____

Name _____ Phone Number _____ Relationship to Patient _____

Emergency Contact: (Please list one individual not living at the same address)

Name _____ Phone Number _____ Relationship to Patient _____

Name _____ Phone Number _____ Relationship to Patient _____

All information signed and authorized by me on this form shall remain in effect until my written revocation.

_____ Initial/Date

HIPAA PRIVACY NOTICE ACKNOWLEDGMENT

By initialing below, I acknowledge that I have been advised of the Notice of Privacy Practices of Riverview Health and may obtain a written copy upon request or via the website at www.riverview.org.

_____ Initial/Date

Patient or Legal Guardian's signature if patient is a minor _____ Date _____

STAFF USE ONLY

Riverview Health Physicians personnel witnessing form completion. _____

Date: _____