## RIVERVIEW HEALTH PHYSICIANS

PATIENT INFORMATION	N				TAR TO THE		WHEN WANTED
PATIENT NAME:		PF	EFERRED (	NICK) NAME:			CEV.
BIRTH DATE:	SOCIAL SECURITY #:		,		Y CARE PHYS	CICIANI.	SEX:
ADDRESS:					CITY:	SICIAIN.	
COUNTY:		STATE:			ZIP:		
HOME PHONE: ( )	)	WORK: (	( )		- terri	CELL: (	1
Circle One: PREFERRED LANGUAGE:	Preferred			Preferred		CELL.	) Preferred
PREFERRED LANGUAGE.			IN7	TERPRETER N	NEEDED:	Yes No	
MARITAL STATUS: Married-	-Single-Widowed-Divorced-N	∕linor S	POUSE NA	ME & PHONE:	:	Circle One	
	can American - Hispanic - Asi Circle One	ian - Americar	ı Indian - Oth	ner	ETHNICITY:		Non-Hispanic
PREFERRED METHOD OF CO	ONTACT: Phone - Postr	al Mail - My Ch	hart	E-MAIL:		Circle	Опе
EMPLOYER:		Circle One: Preferre			Cull-fime	Deet time	
DESCRIPTE DADEVE					Water and the Control of the Control	Part-time Circle One	
RESPONSIBLE PARTY D	EMOGRAPHICS - PLE	ASE INDIC	CATE IF S	AME AS AB	OVE AND	DON'T DU	IPLICATE INFO
RESPONSIBLE PARTY NAME:	:				TO PATIENT:		TEIGHTE IN G.
ADDRESS:					CITY:	1	
COUNTY:		STATE:			ZIP:		
SOCIAL SECURITY:	SEX:		A				
HOME PHONE: ( )		WORK: (	)		m	CELL: (	1
EMPLOYER:		E	MPLOYMEN	T STATUS:		Part-time	Refired
SUBSCRIBER DEMOGRA	ADUICE DI EASE IND	AATE IS O				Circle One	
SUBSCRIBER DEMOGRA SUBSCRIBER NAME:	PHICS - PLEASE INDI	CATE IF S	AME AS A	BOVE AND	DON'T DU	PLICATE	INFORMATION
ADDRESS:				RELATION T	TO PATIENT:		
CITY:		STATE:			710.		
EMPLOYER:			MPLOYMENT	T STATUS:	ZIP: Full-time	Part-time	Defined
PARENTIGI IARDIAN/FAM	ALVINEOPRATION (C					Circle One	Retirea
PARENT/GUARDIAN/FAM	ILY INFORMATION (C	omplete to	r minor pa	atients only			
MOTHER'S NAME:					ere altre and a second		
HOME PHONE: ( )		WORK: (	)		i	oru./	
Circle One:	Preferred			Preferred		CELL: (	) Preferred
FATHER'S NAME:							
HOME PHONE: ( )	Maria de la Companya del Companya de la Companya de la Companya del Companya de la Companya de l	WORK: (	)			CELL: (	Y
Circle One: PATIENT'S PRIMARY RESIDEN	Preferred			Preferred		ELL.	Preferred
THERE OF IMMUNES INCOME.	ICE: (Circle One)  NAME:	Mother	Father	Both	Other:		
SIBLINGS:	NAME:				AGE:	1 11	SEX:
(PERSON TO THE ESTATE TRANSPORTED	NAME:				- AGE: _		SEX:
WINGUIDED	TV-UILLE.				_ AGE:_		SEX:
JNINSURED							
do not have insurance and	understand that I am f	inancially re	esponsible	for the char	ges incurre	d.	
- attent ouardian org	malure:					Date:	والصوارات
NORKER'S COMPENSATION	ON INSURANCE (If Ap	oplicable)	1				
your visit is related to a work inju	ry please notify the reception	nist and provi	de your emp	oloyer informati	ion.		
SIGNATURE OF INDIVIDUA	AL COMPLETING FOR	M					
Signature:					Date:		
					Du.o.		

## **Patient History Form**

Patient Name:			Marita	Status: S		* * * * * * * * * * * * * * * * * * *
DOB: / / SSN:					ΛΙD	W
Name of person/physician	making referral	:	Age:	Gender: M_	F	N A
Primary Care Physician/Far	nily Doctor:					
Body Part:	Right	Left Both	A cuto I	-i(B) - \ \ \		
Please describe reason for	visit and any syr	nntoms	Acute	njury(New): Yes_	No	0
On a scale of 1-10, circle the Approximate date sympton	number that b	est describes v	our pain.	least 0 1 2 3 4	F 6 7 9 0 1	0.6
7	ns began or date	of injury:	<u> </u>	10000 0 1 2 3 4	30789]	u Severe
Resulting from: Sports	Accident	Work Re	elated	Involving Lit	igation	
Are Symptoms: Constant	Intermitten			Improving	igation	
Check All That Apply: Pain_	Stiffness	_ Swelling_			Neumala	· · · · · · · · · · · · · · · · · · ·
What makes symptoms wor				-y wcalliess	Numbr	ness/Tingling
What makes symptoms bet	ter?				III.	
What previous formal treati	ment have you h	nad on this boo	dy part?(N	Nedications, thera	DV. SUPPERV. i	niections)
				,	py, surgery, t	injections)
Were treatments helpful to	any degree? If s	o, what?				
	SAMPLE IN ACCOUNT OF					
	Past Su	rgical History a	nd/or Ho	spitalization		
Previous: Type of operation 1.	or reason for ho	spitalization		The state of the s		
2.						
3.						
4.						
Any previous fractures? Yes	No		Any other	r serious injuries?	Yes	No
		Medication I	nformatio	on - Line		
Do you have any drug allergi	es? YesN	lo	Are you a	allergic to latex? Y	res No	
If yes, name the drug and typ	e of reaction (i.	e. rash, nause	a, etc.) PL	EASE BE SPECIFIC	100	
				and the second		
Current Medications: (List any y Name of Drug	ou are taking at t	his time. This in	cludes iten	ns such as aspirin, vi	itamine lavatio	tos enlaitem to h
Name of Drug	Dose/Str	ength	Nui	mber of Pills	How long	have you taken?
					How long	nave you taken?
				*		
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				19		
					<del> </del>	
		-	-		-	
verview.org						

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## RHP COMMUNICATION OF PRIVATE HEALTH INFORMATION AUTHORIZATION

Plea	ient Name:	DOB:_		
100000	ase √ and fill out all that	are acceptable forms of	communication to pr	ovide quality patient care.
	- Stall Of K	IVERVIEW Health Physicians	to leave a message re	egarding my Private Health Information of
	I authorize the staff of R my cell phone voicemail	iverview Health Physicians	to leave a message re	garding my Private Health Information c
	I authorize the staff of Ri my work voicemail or an	iverview Health Physicians	to leave a message re	garding my Private Health Information o
	l authorize the staff of Ri	verview Health Physicians	o mail written commu	nication to my home address.
	Financial information.	verview Health Physicians t	o speak with the follow	ving individuals to discuss Medical and/o
Vledi	ical:			
lame			Phone Number	Relationship to Patient
ame				· Olatoriship to Patient
		3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Phone Number	Relationship to Patient
inar	ncial:			
ime '			Phone Number	Doloff
me				Relationship to Patient
			Phone Number	Relationship to Patient
	gency Contact: (Pleas	- I of one mulvidual no	t living at the same	e address)
	o made. (I leas	- I of one murridual no	Phone Number	Relationship to Patient
me	e de la composición della comp	o liot one murvidual no	Phone Number	
me			Phone Number Phone Number	Relationship to Patient  Relationship to Patient
me I info	ormation signed and auth Initial/Date PRIVACY NOTICE AC	norized by me on this form	Phone Number  Phone Number  shall remain in effect	Relationship to Patient  Relationship to Patient  ct until my written revocation.
me info	Initial/Date  PRIVACY NOTICE AC	norized by me on this form	Phone Number  Phone Number  shall remain in effect	Relationship to Patient  Relationship to Patient
me info	Initial/Date  PRIVACY NOTICE AC	norized by me on this form  KNOWLEDGMENT	Phone Number  Phone Number  shall remain in effect	Relationship to Patient  Relationship to Patient  ct until my written revocation.
me info	PRIVACY NOTICE AC ling below, I acknowledge written copy upon reques	Norized by me on this form  KNOWLEDGMENT  that I have been advised or tor via the website at www.	Phone Number  Phone Number  shall remain in effect	Relationship to Patient  Relationship to Patient  ct until my written revocation.
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PAA initia ain a	PRIVACY NOTICE AC ling below, I acknowledge written copy upon reques Initial/Date Legal Guardian's signature if pa	Norized by me on this form  KNOWLEDGMENT  that I have been advised or tor via the website at www.	Phone Number  Phone Number  shall remain in effect	Relationship to Patient  Relationship to Patient  ct until my written revocation.
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info	PRIVACY NOTICE AC  ling below, I acknowledge written copy upon reques  Initial/Date  Legal Guardian's signature if pa	KNOWLEDGMENT that I have been advised or tor via the website at www.	Phone Number  Phone Number  shall remain in effect  the Notice of Privacy riverview.org.	Relationship to Patient  Relationship to Patient  ct until my written revocation.  Practices of Riverview Health and may
PAA initia ain a	PRIVACY NOTICE AC  ling below, I acknowledge written copy upon reques  Initial/Date  Legal Guardian's signature if pa	KNOWLEDGMENT that I have been advised or tor via the website at www.	Phone Number  Phone Number  shall remain in effect  the Notice of Privacy riverview.org.	Relationship to Patient  Relationship to Patient  ct until my written revocation.  Practices of Riverview Health and may