Joan Helena Rose, M.D., F.A.C.S.

Patient Name: ______________________________ Date: __________

Have you met Dr. Rose? **Yes** **No** When? ____________________

Have you been treated by Dr. Rose for a prior problem? **Yes** **No** When? ______

Which is your dominant hand? **Left** **Right**

For which specific issue/problem are you being seen today?

____

____

Is this an injury? **Yes** **No** If yes, when and how did your injury occur?

____

____

Is this injury work related or automobile related? **Yes** **No**

If this is **not** an injury, when did your symptoms first occur? ______________

Please list any questions you would like to ask Dr. Rose pertaining to your visit today:

____

____

Date of last Tetanus shot: ____________

Family History: Please indicate which family member(s)
Diabetes ____________ High Blood Pressure ____________ Cancer __________
Other: ____

Have you ever smoked cigarettes? **Yes** **No** If yes, what age did you start? ______
How many? __________ If you have stopped smoking, what age did you quit? _____
Have you ever used chewing tobacco? **Yes** **No**
Recreational drugs: ___________

Alcohol Intake: **None** **Occasional** **Moderate** **Heavy**

Please list any allergies you have. Example: Food, Medication, Materials, Environmental

Allergy	Reaction

Pharmacy Name: ______________________________ Phone Number: ________________
Address: ____

Please list all medications you are currently taking:

Name of Medication	**Dose**	**Frequency**

Are you taking any anti-inflammatory medications? **Y** **N**

If yes, for what condition do you take them? **If no**, why not?

Please review the following statement, which will allow our office to download your medication history into your electronic medical record. This ensures that our practice has your most current medications, to prevent potentially dangerous prescription interactions.

I authorize Hand Associates, P.C. to download my medication history from my insurance provider's pharmacy benefit manager. This information will be used in my electronic medical record, and will be updated at each subsequent office visit.

____
Signature of patient or patient's legal guardian

Please indicate if you decline: ____

Please list any previous surgeries and procedures you have had:

List	**Physician**	**Year**

Is there anyone you would like us to release to or share with your medical information?
Name: ________________________________ Relationship: __________ Phone #: ________

Patient's Signature: ___________________________ **Date**: ____________

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

Purpose: This form is intended to obtain your permission to participate in a telemedicine consultation.

Telemedicine is the use of video conferencing to enable healthcare providers at a different location to provide health care treatment to you and/or consult with you and your health care provider about your health care options and decisions. Telemedicine consultations are not the same as direct patient/healthcare provider visits, as you will not be in the same location as the consulting provider. Telemedicine allows Joan H Rose MD, Hand Associates, PC to provide services to you that may otherwise require you to travel long distances. Your participation in any telemedicine consultation is completely **voluntary.**

Process: By signing this form, you are acknowledging that you understand the following: Details of your medical history, including but not limited to, images, x-rays and tests may be shared electronically and discussed with the consulting provider. A physical examination may take place. Non-medical personnel may be present to assist in operating video conferencing equipment. You will be informed of any non-medical personnel present during the video conference. Video, audio, and/or photo recordings may be taken during the procedure to aid in documenting the progress of your treatment. The responsibility of the consulting provider regarding your health care will terminate upon conclusion of the teleconference. Your provider as well as the consulting provider may keep a record of the consultation.

Possible Risks: By signing this form, you are acknowledging that you understand the following: Despite our best efforts to protect the privacy of patient information, security protocol could fail causing a breach of privacy of personal medical information. Information provided by telemedicine to the consulting provider may be insufficient to allow for treatment and general medical care decisions to be made. Delays in medical evaluation and treatment may occur due to failures of the electronic equipment.

Consent: By signing this form, you are consenting to participate in a telemedicine consultation. You are acknowledging that you have read and understand the provisions in this form. If you are unable to read, you are acknowledging that your health care provider has read this form to you. You are acknowledging that your health care provider has explained to you how telemedicine video conferencing works. I hereby consent to participation in a telemedicine consultation.

Signed X____ **Date:**

Printed name:

WitnessX____ **Date:**

Printed name: