

PLEASE PRINT

**RALEIGH HAND CENTER, P.A.
INFORMATION & INSURANCE RECORD**

DATE: _____

Patient Information:

Full Name: Mr./Mrs./Ms/Dr. (Last) _____ (First) _____ (Middle) _____

Birthdate: ____/____/____ Age: _____ Sex: (circle) M F Social Security # _____

Are you right or left handed? _____

Marital Status: (circle) _____ Child Single Married Divorced Widowed Separated

Home Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address if different from above: _____ City: _____ State: _____ Zip Code: _____

Home Phone: () _____ Work Phone: () _____ Mobile/Beeper: () _____

Occupation:

Employer Name: _____ Address: _____ Phone: () _____

Work Status (circle): Full Time Part Time Unemployed Self-employed Student Retired Disabled

Full name of physician who referred you: **Full** Address: _____ Phone: () _____

Full name of primary care physician: **Full** Address: _____ Phone: () _____

Please give a brief description of your problem:

Date symptoms started:

Is your problem related to an accident? Yes No Type of accident: Job Motor Vehicle Other

Do you have any of the following? (circle): Diabetes High Blood Pressure Heart problems
Asthma/COPD Stomach ulcers Arthritis

Have you experienced any of the following in the last 3 months? (Please check)

- Weight loss Fever/chills Fatigue Joint Pain Joint swelling
- Numbness Hepatitis HIV Skin rashes Nausea/Vomiting
- Diarrhea Chest pain Shortness of breath Thyroid disease Seasonal allergies

Please list all other medical conditions: _____

Please list past surgeries/operations: _____

Current medications: _____

List any drug allergies: _____

Social History: Tobacco? YES NO Packs/day _____
Alcohol? YES NO Amount _____

Family History: Has anyone in your immediate family (Mother, Father, Siblings, Children) had any of the following? (Please check & identify which family member)

Arthritis: _____ Diabetes: _____ High Blood Pressure: _____

Cancer (type): _____ Heart Disease: _____

All items on this page were reviewed by _____ (MD initials) on the date of patient's first examination.

Spouse Name: Birthdate: Social Security #:

Employer: Work Phone: ()

Emergency Contact Person, other than spouse: Phone: () Relationship to patient:
Name: Address:

Primary Insurance Carrier:

Policyholder: Birthdate:
ID Number: Group Number:
Social Security Number:
Employer & Address:

Relationship to patient: Self Spouse Parent Other

Secondary Insurance Carrier:

Policyholder: Birthdate:
ID Number: Group Number:
Social Security Number:
Employer & Address:

Relationship to Patient: Self Spouse Parent Other

If your visit is due to a Workers Compensation claim, you must have a written referral or your visit must be pre-approved prior to your appointment. Failure to provide this information will result in your visit being rescheduled.

Workers Compensation Information:

Claim Number: Contact Person: Phone Number: ()

Employer/Insurance Carrier:
Address:

If patient is a minor, please fill out this section

Father's Name: Phone: ()

Address:

Employer: Phone: ()

Mother's Name: Phone: ()

Address:

Employer: Phone:()

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any services rendered. I also agree to assign insurance benefits to Raleigh Hand Center, P.A. and hereby authorize the release of any information to an insurance company or any other party concerning my illness and treatment. I have carefully read and completed all the information on this form. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or to any of the above information.

Patient/Responsible Party Signature

Date