



DATE: _____

PATIENT INFORMATION

Please take the time to complete EVERY section thoroughly and accurately as it will be a part of your medical record

Patient Name: _____ **Date of Birth** _____

Age: _____ **Gender:** _____ **Preferred Language:** _____ RIGHT or LEFT handed?

Home phone: (_____) _____ **Cell phone:** (_____) _____

Email: _____

Home address: _____ **City** _____ **State** _____ **Zip** _____

Referring Physician: _____ **Primary Care Physician:** _____

Occupation: _____ **Employer:** _____

Work status: Full Time Part-Time Unemployed Stay-at-Home Parent Student Retired Disabled

Ethnicity: Hispanic or Latino Non-Hispanic Prefer not to answer

Race: American Indian or Alaska Native Asian Black or African-American Native Hawaiian or Pacific Islander
 White Other Prefer not to answer

Please describe your problem: _____

Date of symptom onset or Date of Injury: _____

Is this due to an injury? Yes No If YES, what type? Motor Vehicle Work-related Other: _____

Have you had any of the following studies for this problem? ***Please bring a copy of images/reports***

X-rays MRI Nerve study (EMG) CT scan

If yes, what facility did the study? _____

MEDICATIONS: Please list your local pharmacy information and all medications, including doses.

Pharmacy	Address	Phone Number

If you have a medication list, please provide it and we will take a copy instead of completing this section

Medication	Dose	Frequency

Medication Allergies <input type="checkbox"/> No Known Allergies	Reaction

Please take the time to complete EVERY section thoroughly and accurately as it will be a part of your medical record

MEDICAL HISTORY

Height: _____ Weight: _____

Have you had a pneumonia vaccine? Yes No

Have you had a flu shot in the last year? Yes No

Have you had a bone density scan? Yes No

Have you ever had any of the following conditions? (Please check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Depression | <input type="checkbox"/> MRSA infection |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diabetes | If yes, when? _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Dependency/Abuse | <input type="checkbox"/> Neck problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Eye Disease/Cataracts/Glaucoma | If yes, describe _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD/Acid Reflux | <input type="checkbox"/> Osteoporosis or Osteopenia |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> GI Bleeding | <input type="checkbox"/> Pacemaker in heart |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Gout | <input type="checkbox"/> Problems with Anesthesia |
| <input type="checkbox"/> Blood Clot/DVT | <input type="checkbox"/> HIV/AIDS | If yes, explain _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Headaches | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Cardiac Stent | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Hepatitis or Liver disease | <input type="checkbox"/> Raynaud's |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Kidney Disease or Dialysis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Defibrillator in heart | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Thyroid Disorder |

Please list other medical conditions:

Please list all major surgeries:

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

- | | | | |
|--------------------------------------|--|--|---|
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Fevers/Chills | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Joint or limb swelling |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Depression |

Tobacco use? Yes NO QUIT If yes, how many packs per day? _____

Alcohol use? Yes NO QUIT If yes, how many drinks per week? _____

Family History: Please check if any of your immediate family (**Mother, Father, Siblings**) have had any of the following conditions and their relation to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Arthritis: _____ | <input type="checkbox"/> Diabetes: _____ | <input type="checkbox"/> High Blood Pressure: _____ |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Heart Disease: _____ | <input type="checkbox"/> Anesthesia Problems: _____ |
| <input type="checkbox"/> Malignant hyperthermia: _____ | | |

Your hobbies which use your hands: _____

How did you hear about our practice? _____



PRIMARY INSURANCE INFORMATION

Primary Insurance Company: _____

Name of subscriber: _____ Date of Birth: _____

Relationship to patient: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company: _____

Name of subscriber: _____ Date of Birth: _____

Relationship to patient: _____

Acknowledgement and Authorization to Treat

I hereby acknowledge the medical and insurance information given is true to the best of my knowledge and I understand the terms and agreements made with The Raleigh Hand to Shoulder Center.

I, _____ Patient, Legal Guardian, or Parent, authorize medical treatment by a physician, staff, and/or therapist associated with Raleigh Hand to Shoulder Center.

Date _____

Patient or Legal Representative Signature

Emergency Contact Person

Name: _____

Relationship to patient: _____

Phone number: _____

If the patient is a minor, please fill out this section

Parent's name (or legal guardian): _____

Parent's preferred phone number: _____

Please Read and Sign Below if in Agreement

- The Raleigh Hand to Shoulder Center has the right to release confidential medical information to other parties involved in my care including my insurance company, my referring physician and/or my primary physician.
- If my insurance company requires a referral and I do not obtain one in advance of my appointment, I will be required to make payment in full or reschedule my appointment.
- I understand and agree that I am financially responsible for all **in-network and/or out-of-network** balances owed to The Raleigh Hand to Shoulder Center as assigned by my insurance.
- I understand that a deposit may be required prior to scheduling surgery.
- I understand that certain insurance companies require co-pays for both the **doctor and therapy department** if seen on the same date of service.
- I understand that **some supplies and therapy** equipment are not covered by insurance companies, therefore, I will be asked to pay for them at check out.
- Co-payments will be collected at the time of visit as contracted with the insurance company.
- Physicians may use audio recordings during the visit to help with medical records documentation.

**Authorization for Release of Information
AND Acknowledgement of Receipt of Notice of Privacy Practices**

Patient Name: _____ . I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices from the Raleigh Hand to Shoulder Center, and that I may request a copy of this notice for my records if I choose. Protected health information includes information about my diagnosis, general health information, laboratory tests, and billing information. This is known as the HIPAA policy required by law.

How would you prefer that we communicate with you? **Please answer the following questions:**

Is it OK to leave detailed messages on your answering machine or voicemail? Yes NO

Is it OK to contact you by email? Yes NO

Is it OK for us to discuss your medical care with anyone other than you? Yes NO

Examples would include family, spouse, domestic partner,
adult children, or parents. **Please provide the names of**

these individuals: _____

_____ **Date** _____
Patient or Legal Representative Signature