



PATIENT INFORMATION

** Please accurately complete every section as it will be a part of your medical record **

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

Age: _____ **Gender:** _____ **Preferred Language:** _____ Do you write with ☐ **RIGHT** or ☐ **LEFT** hand?

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 these images and/or reports***

☐ X-rays ☐ MRI ☐ Nerve study (EMG) ☐ CT scan

If yes, what facility did the study? _____

MEDICATIONS: Please list your local pharmacy information, medications, and drug allergies. If you have a medication list, please provide it and we will take a copy instead of completing the medications section.

| Pharmacy | Address | Phone Number |
|----------|---------|--------------|
| | | |

| Medications | | |
|-------------|--|--|
| | | |
| | | |
| | | |

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

MEDICAL HISTORY

Height: _____ Weight: _____

FALL RISK QUESTIONS

Have you fallen down in the last year?

☐ Yes ☐ No

Do you feel unsteady when standing or walking?

☐ Yes ☐ No

Do you worry about falling down?

☐ 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 (RA) |
| <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** not listed above: __________
_____Do you have **Rheumatoid Arthritis (RA)** diagnosed with blood testing? ☐ Yes ☐ NOPlease list all **MAJOR SURGERIES**: _____

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 anyone in your immediate family (parents or siblings) has had any of the following:

- | | | | |
|------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatologic disorders |
| <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: _____

Please note that secondary insurances are filed as a courtesy only. We ask that you make certain that the secondary insurance payments are paid in a timely manner.

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 recordkeeping.
- No-show and late cancellation policy for therapy visits: Missing a scheduled therapy appointment with less than 24 hours notice may result in a \$25 fee. This fee will be collected at check-in prior to the next appointment.

**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, adult children, or parents.

Please provide the names of these individuals: _____

Patient or Legal Representative Signature **Date** _____