RALEIGH HAND TO SHOULDER CENTER

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:** _____ ☐ **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

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Prefer not to answer

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, 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 ☐ 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)

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

Please list **OTHER MEDICAL CONDITIONS** not listed above**:** _____

_____

_____

Do you have **Rheumatoid Arthritis (RA**) diagnosed with blood testing? ☐ Yes ☐ NO

Please 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:

☐ Arthritis	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatologic disorders
☐ Cancer	☐ Heart Disease	☐ Anesthesia Problems	☐ 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, adult children, or parents.

Please provide the names of these individuals: _____

_____

_____**Date** _____

Patient or Legal Representative Signature