GREATER CHESAPEAKE HAND TO SHOULDER

HAND • WRIST • ELBOW • SHOULDER

Intake Form

Please complete all fields

Patient Name | *First Name* | *Middle Name* | *Last Name*

Patient DOB

Patient Age | **Patient Gender**

Patient Occupation | **Patient Employer**

Primary Care MD Name/Number

Consult Requested by Primary Care MD Y N

Circle One

Send Report to Primary Care MD Y N

Circle One

Physician Requesting Consult / Number

If different from PCP

Are You Right Hand Dominant Left Hand Dominant

Circle One

Reason for Visit

Briefly describe how injury occurred or details of illness/injury

Date of Injury/First Symptoms

Illness/Injury Result of

Circle One Auto Accident No Injury / Other

Workers Comp Liability

If WC, I filed a claim Y N

Circle One

State injury occurred in

Past Medical History *(circle those that apply)*

Heart Disease	GI Disorder	Reflux
High Blood Pressure	GU Disorder	Thyroid Disease
Diabetes	Cancer	Hepatitis
Pacemaker	Anxiety	Depression
Blood clots	HIV	Tuberculosis
Sleep Apnea	Lyme Disease	Arthritis
Lung Disease	Gout	Osteoporosis
Irregular Heart Beat		

Past Medical Conditions

(not included above)

If none, please write "none"

Past Surgical History

If none, please write "none"

Medications

If none, please write "none"

Preferred Pharmacy/Number

If you do not have number, please give an identifier of location

Allergies

If none, please write "none"

Latex Allergy Y N

Circle One

Social History Tobacco

Smoker Status (Never, Former, Current Smoker)

Amount Per Day | *Type* | *Years Using/Used*

Quit Date (if applicable) | *Quit Attempts* | *Second Hand Smoke Exposure*

Do you exercise? Y N

Circle One

Do you drink alcohol? Y N

Circle One

Family History

Indicate Who Has/Had Condition (i.e. mother, father, grandparent, etc.)

Heart Disease	
Diabetes	
Cancer	
Sleep Apnea	
Arthritis	
High Blood Pressure	
Gout	
Blood Clots	
Malignant Hyperthermia	

Patient Preferred Language

Patient Race

Circle One

American Indian or Alaska Native
Asian
Black/African American
White
Native Hawaiian or Pacfic Islander
Other
Prefer Not Answer

Patient Ethnicity

Circle One

Hispanic
Not Hispanic

Height (feet)

Height (inches)

Weight (lbs)

Weight (oz)

Review of Systems

Please circle any symptoms you are currently experiencing

Constitutional	Fever	Chills	None of These
Eyes	Changes in Vision	Blurred Vision	None of These
HENT	Hearing Loss/Changes	Verigo/Lightheadedness	None of These
Cardiovascular	Chest Pain	Irregular Heartbeat	None of These
Respiratory	Shortness of Breath	Sleep Apnea	None of These
Gastrointestinal	Bowel Changes/Problems	Abdominal Pain	None of These
Genitourinary	Frequency/ Urgency	Dysuria	None of These
	Difficulty Voiding		
Integumentary	Rash	Itching	None of These
	Changes in Skin Color		
Neurological	Headaches	Weakness	None of These
	Tingling/Numbness	Coordination Changes	
Musculoskeletal	Joint Pain	Joint Swelling	None of These
	Muscle Weakness		
Endocrine	Weight Loss / Gain	Heat/Cold Intolerance	None of These
Psychiatric	Anxiety	Depression	None of These
Heme-Lymph	Easy Bleeding	Lymph Node enlargement	None of These
Allergic/Immune	Frequent Illness	Seasonal Allergies	None of These

Patient Address

Address Line 1

Address Line 2

City

State / Province / Region

Postal / Zip Code

Email

Your email will only be used by our office for communicating with you

Patient Phone

Preferred Number

Alternate Number

Emergency Contact

First Name

Last Name

Phone Number

Relationship

Greater Chesapeake Hand Specialists, PA
Authorization and Financial Responsibility

I hereby authorize Greater Chesapeake Hand Specialists, PA to furnish information to insurance companies concerning my illness and treatment. I hereby irrevocably assign Greater Chesapeake Hand Specialists, PA all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered, or denied by my insurance company. A photocopy of this authorization shall be considered as effective and valid as an original. I also understand that if my workman's compensation claim has not yet been approved, Greater Cheasapeake Hand Specialists, PA is required to file with my private insurance carrier.

I agree that Greater Chesapeake Hand Specialists, PA may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

I authorize Greater Chesapeake Hand Specialists, PA to initiate a complaint to the insurance commissioner for any reason on my behalf.

I authorize Greater Chesapeake Hand Specialists, PA to transfer any overage balance owed to me to any outstanding payment balance due to Lutherville SurgiCenter, LLC on my behalf.

In the event that my account is referred to an attorney or collection agency, I agree to pay reasonable attorney fees and court costs and understand that additional collection fees of 20% may be added to my orginal debt owed. I further agree that all legal proceedings shall occur in Baltimore County, Maryland.

Signed at Greater Chesapeake Hand Specialists, PA

Signature

Date

If financially responsible/insurance person is other than patient/legal guardian please sign below

Signature

Date