

Thank you for choosing Northshore Orthopedic & Sports Medicine Center for your orthopedic care. When preparing for your initial visit with our office please prepare the following for your first appointment:

- Please complete the enclosed paperwork packet and bring it with you to your appointment
- Arrive to your first appointment 30 minutes prior to your scheduled appointment time – 15 minutes for all follow up appointments.
- Bring all insurance cards and a photo ID to your first appointment, we must make copies for our records.
- Co-payments and Co-insurances / deductibles will be collected at the time of service. We accept cash, checks, VISA, Mastercard & Debit Cards as forms of payment. We also accept Care Credit.
- Please complete medication history with all medications, dosages, and physicians' names who prescribe medications.
- Bring any prior medical records relating to current condition, including x-rays, MRI's, CT scans, etc. (film or CD) **failure to do so may require re-scheduling of appointment or x-rays to be taken again; which may not be covered by your insurance plan.
- If you are unable to keep your appointment as scheduled, please call our office 24 hours in advance to reschedule.

If you have any questions or concerns please feel free to contact our office at 704-658-1050 and one of our staff members would be glad to assist you.

Once again; thank you for choosing Northshore Orthopedic & Sports Medicine, we look forward to seeing you very soon!

Best Regards,

David Hillsgrove, MD
James McDonald, MD
Rodney Stanley, MD
Chad Michel, PA-C

Rob Steele, Practice Manager
& our Northshore Associates

Northshore Orthopedic & Sports Medicine Center

Adult

Welcome To Our Office!

Patient Information:

Today's Date: ____ / ____ / ____

Name: _____ SSN: _____ - _____ - _____

Last Name, First Middle

Birth Date: ____ / ____ / ____ M / F Marital Status: S M Sep D W

Mailing Address:

PO Box/Street (Please provide physical address for our records if using PO Box)

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____ Fax #: _____

Employed: FT / PT / Retired Student: FT / PT School: _____

Alternate Address:

PO Box/Street (if local address is seasonal)

City: _____ State: _____ Zip: _____

Is the condition you are here for today related to an "on the job" injury? _____ DOI _____

If the answer is "yes" has this been reported to your employer? _____

Additional Patient Information:

Language: English Spanish Other: _____

Ethnicity: Non Hispanic/Latino Hispanic/Latino Unreported/Refused

Race: American Indian or Alaskan Native / Asian / Black or African American
Native Hawaiian / Other Pacific Islander / Unreported/Refused to report / White

Veteran: yes / no / unknown

Primary Care Physician: _____

(please provide name of doctor, the facility name and their location)

Referred by: _____

(please provide name of doctor, the facility name and their location)

Preferred Pharmacy: _____

(please provide the street name and city) Example: CVS on Main St, Mooresville

Best method to contact you for appointment reminders/test results(phone/email):

#1 _____ #2 _____ #3 _____

Northshore Orthopedic & Sports Medicine Center

Primary Insurance:

Policy Holder Name:

Relationship:

Insurance Information:

Date of Birth:

SSN:

(Complete if different from patient)

Mailing Address:

PO Box/Street

Home #

Cell#

Work #

If you have two insurance plans please provide the following information:

Secondary Insurance:

Policy Holder Name:

Relationship:

Date of Birth:

SSN:

(Complete if different from patient)

Mailing Address:

PO Box/Street

Home #

Cell#

Work #

****We must have insurance cards for both insurance plans to file claims.**

Northshore Orthopedic & Sports Medicine Center

Acknowledgement of Receipt

Our Notice of *Health Information Privacy Practices* provides information about how we may use and disclose protected health information. This policy also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices. This policy has been provided to you to read and is available on our website. You may request a copy at anytime.

By signing this form; you agree you have had the opportunity to read our *Notice of Health Information Privacy Practices*.

We make appointment reminder calls to your primary phone number. Please be aware if you have Caller ID, our office number will be displayed.

I wish to be contacted for results/ call backs in the following manner: (please check all that apply)

- Home Phone_____
- Work Phone_____
- Cell Phone_____
- Email Address:_____ (we will have the ability to email you with appt reminders very soon! Please provide us with your email address so we can add to our new system!)

We must have your permission to discuss your care or medical condition with others including your immediate family; please list other persons to which Northshore Orthopedic & Sports Medicine Center may release information concerning your medical care to:

Name	Relationship	Contact Phone Number
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Name	Relationship	Contact Phone Number
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Name	Relationship	Contact Phone Number
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This consent must be renewed every 12 months and may be revoked at any time with written notification.

Patient Name (print)

Relationship to patient if minor/guardian

Patient Signature

Date

Office Use Only: Entered by:_____Date:_____



Patient Financial Responsibility Agreement

In order for Northshore Orthopedic and Sports Medicine Center to continue providing our patients with quality medical care, we must receive the contracted payment for our services. Ensuring that we are appropriately and promptly paid is our PATIENT'S RESPONSIBILITY.

As a patient of Northshore Orthopedic and Sports Medicine Center, you are hereby agreeing:

- To pay all non-insured charges including your co-pay, co-insurance, insurance deductible, out-of-network charge differential, and all other non-covered charges at the time of service or when otherwise advised. Office visit co-pays or co-insurances will be collected previous to seeing the physician or the appointment will be rescheduled.
- To provide us your current insurance card at the time of EACH service including hospital based services. If you do not provide us with valid insurance information at the time of EACH service, you agree to personally pay all unpaid charges.
- To obtain any required authorization under your insurance plan for our services from your primary care physician and / or insurer prior to each appointment. If you do not receive the required authorization your insurer may not pay us for our services. In these cases you agree to personally pay any resulting unpaid charges.
- To monitor your insurance company's payment of your account and if unpaid within 30 days from the date of service to contact them regarding non-payment. You will respond to additional requirements by your insurer, (such as clarification of benefits), in a timely manner as well as assisting our business office in expediting payment.
- To notify our office 24 hours previous to your appointment if you are unable to attend. No showing for appointments without providing us notice may lead to a formal discharge from our practice.
- To the understanding that the responsibility of payment for services rendered to any dependent children whose parents are divorced or separated is with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.

Further, you agree that your physician and Northshore Orthopedic and Sports Medicine Center have the right to be paid for their services and you acknowledge:

- That unpaid bills older than 90 days from date of service may be turned over to a debt collection agency or attorney for collection. You will be responsible for related collection or attorney fees.
- That you will be responsible for a \$30 fee for a returned check.

Signature: _____ Date: _____

Print Name: _____ Relationship to patient: _____

Patient Health History Form

Last Name: _____ First: _____ Middle Int.: _____ Date: ____ / ____ / ____

DOB: ____ / ____ / ____ Age: _____ Sex: _____ Height: ____ ft ____ in Weight: _____ lbs.

(Please fill out the questionnaire completely so we may better care for your needs)

I was referred by:

- Lake Norman ER
- L.N.Urgent Care
- Lakeside Urgent Care
- My Doctor: _____
- Friend: _____
- Other: _____

What is the date your injury/symptoms started?

____ / ____ / ____ Exact date unknown

Approximately how long have you had this pain?

_____ Days Months Years

Who is your Primary Care Physician/Pediatrician?

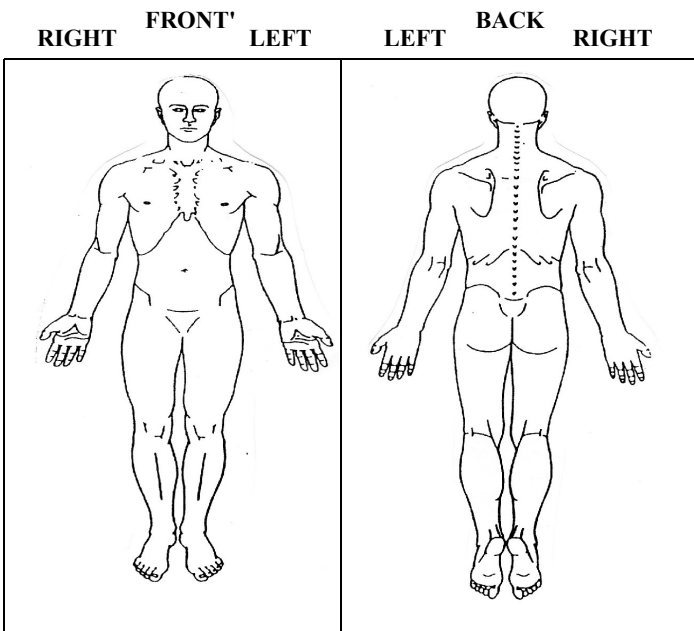
What is the main reason for your visit?

Where is your pain/injury located?

- Left Right Both

Is this a work related injury? Yes No

Please circle the area of your pain.



Describe how your injury occurred: (fall, basketball, football, soccer, etc...)

The pain is worse when I:

The pain is better when I:

I have had the following for this condition:

- Medication
- Physical Therapy
- MRI
- Surgery
- Injections
- X-rays
- CT
- EMG/ Nerve Conduction

Other treatments: _____

Please list all the doctors you have seen for this problem:

- Primary Care Physician
- Chiropractor
- Work Physician
- Other: _____
- ER Physician
- Trainer

Name: _____

Date of Visit: _____

Pain level on 1-10 scale: _____ (1=little to no pain, 10= worst)

Name: _____ Date: ____ / ____ / ____

Current Medications: I am taking no medications.

I take the following medications:
(please include milligrams & how many per day)

I take the following supplements/herbal medications:

Taking blood thinners?

Coumadin Plavix Aspirin Lovenox

Dosage: _____

Medical History: I have no medical problems

List your current medical conditions:

List any recent illnesses, injuries, hospitalizations or history of cancer: _____

Allergies: I have no known allergies

I am allergic to the following: _____

Has anyone in your family had problems with general anesthesia? Yes No

If yes, please explain:

The information above is correct to the best of my knowledge: _____ Date: ____ / ____ / ____
(patient, parent or guardian)

Completed By (please print): _____ Relationship: _____

For Office Use Only

Reviewed by: _____ M.D/P.A. Date: ____ / ____ / ____
signature

Family History:

NONE

- | | |
|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Cancer (type:) | _____ |

List any major health problems with immediate family:
(include diagnosis, age of onset & relationship)

Surgical History: (please list all surgeries)

Social History:

Occupation: _____

Employer: _____

Marital status: Single Divorced
 Married Widowed Separated

Living Situation: w/Spouse Alone
 w/Family Assisted Living

Tobacco use: Never Quit No Yes

If yes, how many packs daily? _____

How many years did you smoke? _____

If you quit, how long have you been smoke free?

_____ weeks months years

Exercise: I do not exercise regularly
 I exercise ____ hours per week

List types of exercise: _____

Alcohol use: Never Yes/Social
Type: Wine Beer Liquor
Amount: _____ per week

Name: _____ **Date:** ____/____/____

Please check the following to describe any medical conditions/ symptoms you may have

General:

- MY GENERAL HEALTH IS GOOD**
 Fatigue Night Sweats Weight loss
 Fever Chills Loss of Appetite

Ear, Nose & Throat:

- NO EAR, NOSE OR THROAT PROBLEMS**
 Ears ringing Hearing loss
 Chronic nose bleeds Sore throat
 Loose or cracked teeth Mouth sores
 Dentures/Partials Crowns
 Mouth/Tooth infection Use a hearing aid

Endocrine/Lymphatic:

- NO LYMPH OR ENDOCRINE PROBLEMS**
 Enlarged Lymph nodes Lymph Edema
 Excessive Thirst Hot Flashes
 Cold sensitivity Weight changes
 Diabetes Thyroid Problems

Gastrointestinal:

- NO STOMACH PROBLEMS**
 Nausea Vomiting
 Constipation Diarrhea
 Gastric Reflux (heartburn) Bowel Incontinence

Hematology:

- NO HEMATOLOGIC PROBLEMS**
 Bleed Easily Bruise Easily
 Anemic Blood clots (DVT)
 Bleeding or clotting disorder

Immunological:

- NO IMMUNE DISORDERS**
 Infections AIDS/HIV

Urinary:

- NO URINARY PROBLEMS**
 Painful Urination Frequent Urination
 Difficulty Urinating Urinary Incontinence
 Chronic Urinary Infections Kidney Problems

OB/GYN: (female)

- NO OB/GYN PROBLEMS**
 Irregular menstrual period Menopause
 Frequent menstrual period

Vision:

- NO EYE PROBLEMS**
 Blurred vision Loss of Vision
 Wear glasses/contacts

Skin:

- NO SKIN PROBLEMS**
 Skin infections Rashes Skin cancer
 Skin ulcers Skin color changes

Neurologic:

- NO NEUROLOGY PROBLEMS**
 Headaches Numbness Seizures Tingling
 Weakness Loss of balance (dizziness)

Mental Health:

- NO M/H PROBLEMS**
 Anxiety Depression
 Sleep Disorders Attention Deficit/Hyperactive

Breast:

- NO BREAST PROBLEMS**
 Breast Cancer Breast Biopsy

Respiratory:

- NO BREATHING PROBLEMS**
 Chest pain Sleep Apnea Lung cancer
 Asthma Difficulty breathing
 Persistent cough Shortness of breath

Vascular:

- NO HEART / VASCULAR PROBLEMS**
 Heart murmur Stroke
 Chest pain Heart attack
 High Blood Pressure Low Blood Pressure
 Pulmonary embolus Raynaud's disease
 Phlebitis Varicose veins
 Leg pain while walking Fainting
 Short of breath laying down

Musculoskeletal:

- NO MUSCULOSKELETAL PROBLEMS**
 Osteoarthritis Fibromyalgia
 Osteoporosis Rheumatoid Arthritis
 Gout Bone cancer
 Connective tissue disorder Lupus
 Reflex sympathetic dystrophy
 Fractures: if so, location(s): _____

- Other Joint Problems: _____

Anesthesia:

- NO PROBLEMS WITH GENERAL ANESTHESIA**
 Have never had general anesthesia
 I have had the following anesthesia problems: _____