Appalachian Shoulder Specialists
Suzanne E. Hall, M.D.
Fellowship Trained Shoulder Specialist,
Board Certified Orthopaedic Surgeon

1027 Fleming Street, Suite B (Lower Level)
Hendersonville, NC 28791
Phone (828) 697-1944 **Fax (828) 697-3661**

Welcome to our Practice

App. Date: ___________________ **ARRIVE** @: _________________ App. Time: _______________

We value our patient's time and try very hard to stay on schedule.
If you arrive 15 min. or more after your **ARRIVAL** time, the appointment will be rescheduled.

Completing your forms ahead will make your first visit easier and give you a chance to collect the information you need. Attached you will find 5 pages to be completed.
Please bring them, along with your Insurance Cards and Photo ID.

Photo IDs are now required due to the "Red Flag Rule"
(New requirements from the government for fighting identity theft)

If you had X-rays, an MRI, or a Nerve Conductive Study/EMG and they were **NOT** done at Pardee Hospital or the Pardee Outpatient Kayden Building or Pardee Hendersonville Urgent Care, please obtain the CD and written report and bring them to the office at least 2 days prior to your appointment. **If not received prior to your appointment you will need to reschedule to a later date.**
If taken at any of the above locations, we will access them by computer. In that case, you do **not** need to bring the CD and written report.

If Self Pay, (Those without Health Insurance)
Your first visit will typically be between $300.00 and $510.00 depending on what services are performed.
Payment is required in full at each visit.

If Second Opinion or Previous Surgery elsewhere, please obtain copies of the X-rays/MRIs on CD and the Operative report if surgery has already been done. These should be brought at least 2 days prior to your first visit so that they can be carefully reviewed. **If not received prior to your appointment you will need to reschedule to a later date.**
The previous physician's office notes can be very helpful. It is your choice whether you wish to provide those or not before your first visit.

We do not file any Liability Claims (example: Car Accident or Fall at K-Mart) we will give you the information needed for you to give to the Insurance Company. We need your payment at the time of each office visit.

A No-Show Fee of $75 will be charged to patients (not their insurance carrier) for missed / No-show office appointments. This charge MUST be paid before another appointment can be scheduled. This policy helps to ensure that our patients who need to be seen by our doctor can obtain an appointment with us in a timely manner.

We look forward to providing you with quality Orthopaedic care.
If you have any questions, feel free to call at (828) 697-1944

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Name ____
Last First Middle Initial

Social Security #: ______________________________________

Date of Birth: __________________________ Age: ___________

Marital Status

☐ **Male** ☐ **Female** / ☐ **Married** ☐ **Single** ☐ **Widowed**

Home Phone #: ____

Cell Phone #: ____

Mailing Address: _______________________________________

Apt/Unit: ____

____
City State Zip Code

Driver's License No. _______________________ State: ________

Primary Care Physician: _________________________________

Phone Number: ____

Responsible Party Information (If different than patient)

Name ____
Last First Middle Initial

Home Phone# ____

Mailing Address ____

____
City State Zip Code

Relationship to patient: ____________________________________

INSURANCE INFORMATION

▼COMPLETE INFORMATION BELOW ▼

Please bring your insurance cards to your visit

Primary Ins: ____

Policy Holder's Name: ____________________________________

Policy Holder's Date of Birth: ______________________________

SS# If Needed to File Claim: _______________________________

Secondary Ins: ____

Policy Holder's Name: ____________________________________

Policy Holder's Date of Birth: ______________________________

SS# If Needed to File Claim: _______________________________

Where did you hear about our office? Referred by ____________________________
Word of Mouth ___, Internet search___, Newspaper Ad____
Other________________

Reason for today's visit: ☐ **Right or** ☐ **Left** ________________________

Treated Here Previously? ☐ **Yes or** ☐ **No**

☐ **Date of Injury** _______________
State Injury Occurred _____________

or

☐ **Date Pain Started** ____________________________

FINANCIAL RESPONSIBILITY / CONSENT FOR TREATMENT

Patient's deductible and co-pay are due at time of each visit.

I have read and fully understand the financial policy established by Suzanne E. Hall, M.D. I agree that insurance payments to be paid to Appalachian Orthopaedics, Suzanne E. Hall, M.D. on my behalf. I understand that I am financially responsible for all charges not paid by insurance with exception of approved Medicaid and approved Worker's Comp accounts. In the case of a minor, the child's guarantor is responsible for the account. Our **Notice of Privacy Practices** is available in our office**.** I certify the information on this form is true to the best of my knowledge.
I give permission to **Appalachian Shoulder Specialists** to provide health care to myself or the above named dependent.

► **Patient Name (Please Print)** _____________________________________ **Date:** ______________________

► **Patient Signature:** ____

Guardian's Signature (if patient is a minor) _________________________ **Relationship:** ________________

MEDICAL HISTORY Patient Name: ______________________________ Date: _________________

Current Medications / Dosages

1. ____ 5. ____
2. ____ 6. ____
3. ____ 7. ____
4. ____ 8. ____

☐ **NOT ON ANY MEDICATIONS** ☐ **SEE ATTACHED LIST**

List drug allergies or problems with medications **(Problem: nature of allergic reaction)**

1. ____________________________________ 4. ____________________________________
2. ____________________________________ 5. ____________________________________
3. ____________________________________ 6. ____________________________________

☐ **NO DRUG ALLERGIES OR PROBLEMS** ☐ **SEE ATTACHED LIST**

Previous Surgery **Year of surgery** **Complications**

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____

☐ **NO PREVIOUS SURGERIES** ☐ **SEE ATTACHED LIST**

Height: _______________ **Weight:** ________________ **Local Pharmacy**_______________________

Medical History: At any time have you ever had?

Town/Phone__________________________

☐ Diabetes ☐ **Type 1 or** ☐ **Type 2**

☐ Stroke

☐ Heart problems: ☐ **A-Fib** ☐ **Coronary Artery Disease**

☐ Peripheral Vascular Disease

☐ High blood pressure

☐ High cholesterol

☐ Anemia

☐ Blood clots / DVT

☐ Bleeding disorder

☐ Breathing problems ☐ **Asthma** ☐ **COPD** ☐ **Other**

☐ Liver disease/hepatitis

☐ Glaucoma

☐ Stomach ulcers ☐ GERD

☐ Bowel/intestinal problems

☐ Kidney disease/stones

☐ Treatment for Drug or Alcohol Problems

☐ Cancer: ____________________________________

☐ Urinary problems ☐ Incontinence ☐ UTI's

☐ Prostate disease (Males)

☐ Peripheral Neuropathy

☐ Ears, nose, throat, or mouth problems

☐ Joint dislocations or Double jointed

☐ Balance problems

☐ Marfan's disease

☐ Skin disease

☐ Neurological disorder: _________________________

☐ HIV/AIDS

☐ Thyroid trouble

☐ Hearing Aids

☐ Mental health disorders: _______________________

☐ Gout

☐ Rheumatoid Arthritis

☐ Other: ____________________________________

☐ **NONE OF THE ABOVE**

Patient Name: ______________________________________Date: ______________

Do you have an Advance Care Plan? ☐ no ☐ yes (Please provide us with a copy)
Do you have a designated Power of Attorney? ☐ no ☐ yes Name: _________________________

Family History: Have any of your blood relatives had?
☐ Heart Disease ☐ High Blood Pressure ☐ Cancer ☐ Diabetes ☐ Rheumatoid Arthritis
☐ Malignant Hyperthermia ☐ **None of the above**

The Government requires us to ask the following questions (Please Answer All Three or Decline is fine)

1. Race: ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **African American**
☐ **Native Hawaiian or Another Pacific Island** ☐ **White** ☐ **Other Race**

2. Ethnic Group: ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino or** ☐ **Declined**

3. Language: ☐ **English** ☐ **Spanish** ☐ **Arabic** ☐**Chinese** ☐ **French** ☐ **German**
☐ **Japanese** ☐ **Russian** ☐ **Vietnamese or** ☐ **Other**

OR ☐ **Decline to answer all**

Employment: ☐ Full Time ☐ Part Time Occupation: ______________________________

Employers Name: ____

Employers Phone#: ____

☐ **Retired** ☐ **Disabled** ☐ **Unemployed** ☐ **Homemaker** ☐ **Child/Student**

Retirees: Prior Occupation__________________________________

Number of children _________ **Do you live alone?** ☐ Yes or ☐ No

This information helps Dr. Hall determine what hobbies you can continue doing or should temporarily stop doing because of your pain or injury.

Hobbies/Activities: ☐ Weight lifting ☐Golf ☐ Kayaking ☐ Gardening ☐ Fishing ☐Musical Instruments
☐ Travel ☐ Bow Hunting ☐ Bicycling ☐ Motorcycling ☐ ________________________
☐ ____

The Government requires us to ask the following questions about Smoking

Current Smoker: ☐ **No** ☐ **Yes** ______ **Packs/Cans a day** ☐ **Cigarettes** ☐ **Cigars** ☐ **Smokeless Tobacco**

Former Smoker: ☐ **No** ☐ **Yes** ______ **Year Stopped** ☐ **Cigarettes** ☐ **Cigars** ☐ **Smokeless Tobacco**

Alcohol use: ☐ **Never** ☐ **Rare** ☐ **Social** **How many times** _______ **a** ☐ **Day** ☐ **Week** ☐ **Month**

Patient Name: ___________________________________Date: _____________

HIPAA PERMISSION RELEASE

Individuals listed below are those with whom Appalachian Shoulder Specialists employees may discuss my account, medical diagnosis, test results, pathology reports, medications, or other information regarding my health care.

►Emergency Contact Name: _______________________________________

Phone Number: ________________________Relationship: ________________

Name: ____

Phone Number: _________________________Relationship: _______________

Name: ____

Phone Number: _____________________Relationship: _____________________

Name: ____

Phone Number: ______________________Relationship: ____________________

If you were NOT referred by your primary care physician and would like us to send today's office note to another provider, please list their full name & phone number below.

Physician Name: ____

Phone #: ________________________

You may leave a message on: (Please check below)

☐ my home phone

☐ my cell phone

☐ my work phone

►Patient Name: ____

Please Print

►Patient Signature: _______________________________________

Or Guardian's Name

►Date: ________________________

Please review to make sure all information has been completed. Thank You