Cape Fear Sports Medicine, PA
5710 Oleander Drive • Suite 108 • Wilmington, NC • 28403
Phone: 910-790-9714 • Fax: 910-791-1063

____New Patient ____ Existing Patient Date:_____

Patient Information:

Patient's Name_____
LAST FIRST MI

Address:_____

_____

City:_____State____Zip:_____

Home Phone:_(___)_____

Work Phone:_(____)_____

Cell Phone (____)_____

□ Male □ Female

Birth Date:____/_____/_____ Age _____

Pt's Social Security #:_____-_____-_____

Referred by:_____
(If another Doctor, who?, Yellow Pages, Friend, etc)

Emergency Contact:
Name:_____
Phone:_____Relation:_____

E-Mail Address:_____
Are You Employed? Y___ N___ How Long?_____

Occupation:_____□FullTime □PartTime

Employer:_____

Drivers License #:_____
Number State

□ Married □ Single □ Divorced □ Separated □Widowed

Spouse's Name:_____
Spouse's Employer:_____

Are you a student? Yes___ No___
If yes, Full time___ Part time___
School_____ Grade_____

Responsible Party (RP) Information:

□ **Same as Patient** (18 yrs and older)

RP Name:_____

Address:_____

City:_____State:_____ Zip:_____

Home Phone:_(_____)_____

SS #:_____-____-_____ Birthdate:____/____/_____

RP Occupation:_____

Employer:_____

Address:_____

City:_____State:_____ Zip:_____

Work Phone:_(____)_____

****Give your insurance cards and picture I.D. to the receptionist to make a copy for our records****

Current Problem:

Describe your current problem_____

When did this problem begin?_____ If accident, give date of accident:___/___/___

Were you injured on the job? Yes_____ No____If yes, give date of accident:___/___/___

Auto Accident? Yes_____ No_____ If yes, give date of accident: ____/____/____

Benefit Assignment / Agreement to Pay:

I hereby authorize my insurance benefits to be paid directly to Cape Fear Sports Medicine. I understand that I am responsible to Cape Fear Sports Medicine for payments made directly to me and for any services or charges not covered by my insurance carrier or out-of-state Worker's Compensation claim.

Authorization to Release Medical Information/ Release for Treatment:

I hereby authorize Cape Fear Sports Medicine to release medical information (which may include treatment for physical / emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS or AIDS-related information) to the patient's insurance carrier and its designated and, in Worker's Compensation cases, to the patient's employer.

***Signature of Patient or Legal Guardian:_____Date:_____**

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____New Patient ____ Existing Patient Date:_____

Medical History

Name:_____ Age:_____ Birth Date:_____

Please circle "Y" below if you have problems with these medical conditions, or "N" if you do not:

Skin/Breast:
Y N Rash or problems with itching
Y N Varicose veins
Y N Breast lump

Eyes/Ears/Nose/Mouth/Throat:
Y N Blurred or double vision
Y N Eye diseases
Y N Hearing loss or ringing
Y N Earaches or ear drainage
Y N Sinus problems or "runny nose"
Y N Nose bleeds
Y N Loose or chipped teeth
Y N Dentures or bridge
Y N Problems opening mouth wide
Y N Sore throat or change in voice
Y N Swollen glands in your neck

Lungs:
Y N Breathing problems o r asthma
Y N Breathing problems during sleep
Y N Tuberculosis or emphysema

Cardiac (Heart or Blood Vessels):
Y N Chest pain or angina pectoris
Y N Heart disease or heart trouble
Y N Recent chest pressure or tightness
Y N Shortness of breath on exertion
Y N Shortness of breath when lying flat
Y N High blood pressure
Y N Recent heart palpitations
Y N Swelling of feet, ankles, or hands
Y N Bleeding disorder
Y N Take a blood thinner, eg.Coumadin

Endocrine:
Y N Diabetes or high blood sugar
Y N Do you take Insulin?

Intestines and Kidneys:
Y N Frequent/ burning /painful urination
Y N Blood in your urine
Y N Urinary incontinence or dribbling
Y N Kidney stones
Y N Kidney or liver disease
Y N Males: Testicle pain
Y N Males: Prostate problems
Females: Number of Pregnancies:___
Y N Change in bowel movements
Y N Nausea or vomiting
Y N Frequent diarrhea
Y N Rectal bleeding or blood in your bowel movements
Y N Freq. abdominal pain / heartburn

Musculoskeletal:
Y N Arthritis
Y N Osteoporosis
Y N Major Fractures

Neurological (Nerves):
Y N Frequent, recurring headaches
Y N Dizziness
Y N Numbness or tingling sensations
Y N Convulsions, seizures, or tremors
Y N Any kind of head injury
Y N Stroke or "mini stroke"

Psychiatric:
Y N Memory loss or confusion
Y N Feelings of nervousness
Y N Feelings of depression
Y N Trouble sleeping

Social:
Y N Drink alcoholic beverages
If yes, how much?_____
Y N Use any recreational drugs
Y N Smoke
If yes, how much?

Anesthesia History:
Y N Any anesthesia problems other than nausea or vomiting?
Y N Difficulty opening your mouth?
Y N Family history of malignant hypertension?
Y N History of prolonged weakness after anesthesia?

Family History:
(circle Y for all that apply)
Y N Diabetes
Y N Bleeding Tendency
Y N Cancer
Y N Sickle Cell
Y N Hypertension
Y N Heart Disease

Past Surgeries / Where? / Problems?
_____ **Y N**
_____ **Y N**
_____ **Y N**

Recent Procedures/Tests When? Where?
_____
_____
_____
_____

Other Medical Problems:
_____
_____
_____
_____
_____
_____
_____

Medications Dose How often?
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Drug Allergies:
_____
_____
_____
_____
_____

Are you allergic to latex gloves?
_____Yes _____No

Height:_____ Weight:_____

Primary Care Physician:_____

I certify that this information is correct to the best of my knowledge. I will not hold my doctor or any members of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____
Patient Signature Date

Provider Reviewed:

_____

Dale Boyd Jr., MD Debbie Sherman, PA-C

Date:_____