SOUTHEASTERN SPORTS MEDICINE, PLLC

7 Turtle Creek Drive Asheville, NC 28803

DATE ____________________ PATIENT INFORMATION

PATIENT NAME: ____
Last First Middle

( ) Child ( ) Single ( ) Married ( ) Widow(er) ( ) Divorced

Address: ________________________________ City ________________ State__________ Zip ________

Phone ( ) ____________________ Cell ( )___________________ Work ( )_____________________

Male _____ Female _____ Date of Birth ___________________ Age ________ SS# _________________________

Patient's Employer: _________________________ Address: ____

Patient's School (Student) ____________________________COACH: ______________________________

Spouse's Name: ____________________________ Spouse's Employer: ______________________________

Children (if any), Names, & Ages: ____

RESPONSIBLE PARTY: Person responsible for payment today and after insurance payment (if any).

Name of Responsible Party/Parent/Guardian: ____

Address: ________________________________ City ________________ State__________ Zip ________

Phone including Area Code: ____________________ Date of Birth ______________ SS# __________________

INSURANCE INFORMATION:

1. Primary Insurance Company ________________________________ Insured Person_____________________
   Insured's Social Sec #__________________DOB:__________________ Employer ______________________
   Policy Number ______________________________________ Group Number ____________________
2. Secondary Insurance Company ________________________________
   Insured Person ______________________________________ Employer ______________________
   Policy Number ______________________________________ Group Number ____________________

WORKERS COMPENSATION INFORMATION:

Employer's Name, Address, and Phone Number:____

____

Worker's Comp Insurance Co Name: ____

Worker's Comp Insurance Address: ____

Worker's Comp Phone: ( ) ________________ Contact: __________________________________

Claim/IC# ______________________________ Date of Injury: ________________________________

EMERGENCY CONTACT & Relationship to Patient: ____

Telephone ( ) ________________________ or ( ) ________________________

HAVE YOU EVER BEEN TREATED BY DR. MAXWELL ____ DR MOTLEY ____ DR. RUDINS ____ DR. JONES____

REFERRED BY: ____

FAMILY DOCTOR'S NAME AND ADDRESS: ____

DATE YOUR PAIN BEGAN:____

Is this a Sports Injury _____ Other Injury ______ Would you like reports sent to your family physician? YES NO

Is a lawyer involved in your case? YES NO Name of Attorney ____________________________________

FINANCIAL POLICY: Payment of deductibles and co-payments is expected at the time of service. Cash, Check, MasterCard and Visa are acceptable methods of payment. Insurance claims for each service date will be submitted to your insurance company. The patient or in the case of a minor, the person bringing the child is responsible for payment.

PAYMENT AUTHORIZATION & ASSIGNMENT: I hereby authorize this physician/clinic to release any information required in the course of my examination or treatment to other healthcare providers. In the case of Medicare, I authorize the release to the Health Care Financing Administration and its agent any information needed to determine benefits payable for related services. I authorize direct assignment of my benefits payable under my insurance to this facility. **I have read and understand the Contents of the Patient Information Practices.**

Signature ____ Date ______________________________

REASON FOR VISIT: ____

When did this problem begin (include date/time if accident): ____

Describe how injury occurred: ____

Have you had this problem before? YES NO

PAST MEDICAL HISTORY

Current Medications (including any non-prescription):____
____

What Medications have you taken in the past for this condition: ______________________________________
____

Do you have any Food or Drug Allergies (please list): ____
____

Do you have or have you had any medical conditions (please list): ____________________________________
____

Have you had any operations (please list with dates): ____
____

Do you have any family history of illness (i.e. Blood relatives, Mother, Father…..) (please list):_________________
____

REVIEW OF SYSTEMS

Please circle any symptoms that you may have:

Constitutional: Fever / Weight loss / Weight gain / Poor appetite / Poor sleep / Night pain / Headaches / Fatigue
Eyes: Double vision / Blurry vision / Blindness / Glasses or contacts / Light Sensitivity
ENT: Deafness / Sinusitis / Ringing in the ears / Hoarseness / Vertigo
CV: Chest pain / High blood pressure / Heart attack / Irregular heart beats / Other heart problems
Respiratory: Shortness of breath / Asthma / Cough
GI: Diarrhea / Constipation / Abdominal pain / Ulcers / Nausea / Vomiting / Bowel incontinence
GU: Bladder incontinence / Trouble voiding / Menstrual problems / Pregnancy
MS: Joint pain / Swelling / Muscle pain / Muscle cramps / Joint stiffness / Arthritis / Fractures / Sprains
Skin/Breast: Rashes / Unusual color or temperature / Skin masses or lesions / Scars / Skin Ulcers
Neurologic: Fainting / Dizziness / Numbness / Tingling / Weakness / Tremor / Seizures / Poor memory / Balance Problems / Stroke / Poor concentration
Psychiatric: Depression / Hallucinations / Mood problems
Endocrine: Heat or cold intolerance / Excessive thirst / Growth or hair changes
Hematologic: Bleeding tendency / Enlarged lymph nodes / Anemia / Tendency to bruise
Allergic: Eczema / Itching / Allergies

DOCTOR'S NOTES:

WORK INFORMATION

What is your job? ____

Is your job satisfying to you? (circle one) Y N

What are the physical requirements of your Job? ___________________________________

Is your problem job-related? Y N
If yes, have you notified your employer? Y N
If yes, does your supervisor or boss support you in your treatment? Y N
If yes, have you been offered alternate light duty? Y N

If out of work, how long? ____

SOCIAL HISTORY

Do you use tobacco or drink alcohol? _____________ If yes, how much per day?__________________________

Do you take any other drugs, nutritional supplements, herbs, caffeinated beverages, etc? YES NO
If YES, please list type and amount: ____

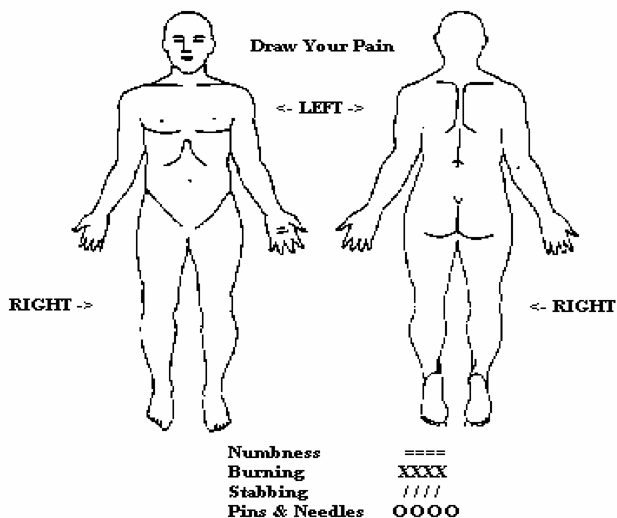
Do you awaken often at night? _________________How much do you sleep per night? ________________________

What are your recreational activities? ____

What is your living situation? ____

What is the level of your education? ____

HISTORY OF PRESENT ILLNESS



Is your pain ………… (Choose Any)

Increased With:	Decreased With:
Coughing	Bowel Movements
Sneezing	Changing Positions
Walking	Changing Positions Frequently
Staying In One Position	Sitting
Lifting:	Elevating Feet
Other: ___________________	Other: _________________
_________________________	_______________________

Which has the worst pain? Neck & Back or Arm & Leg
Have you had previous back/neck problems? (please list) ____

What is your pain level right now on a scale of 1-10, with 10 being the worst pain you could imagine? ______________________

PAST TREATMENTS:
Other health care providers seen: (please list)____
____
Physical Therapy: ____
Chiropractic:____
Braces:____
Acupuncture:____
Injections: ____

Southeastern Sports Medicine
7 Turtle Creek Drive
Asheville, North Carolina 28803
828-274-4555 Office
828-274-8348 Fax

Keith M. Maxwell, MD
Daniel T. Eglinton, MD
Andrew Rudins, MD
Jerome L. Pettit, PA-C
Gregory S. Motley, MD
Lauren D. Brock, PA-C
Richard Jones, MD
Jonathan Swinger, PA-C

Medication Policy

1. Please Call at least 24 to 48 hours BEFORE you are out of medication. There will be no exceptions. Please leave the following information for your refill. Name of Patient, Dr. Name, Name of Medication, and Name of Pharmacy.

2. Refills require 48 hours; please check with your pharmacy before calling back AFTER 48 hours. All refills must be approved by the Dr. before they can be filled.

3. No Early refills.

4. No prescription refills on Holidays, Weekends, or After Hours. NO EXCEPTIONS

X-Ray Policy

If you are a New Patient or being referred by another doctor you need to make sure ALL of your X-Rays are in our office or you are bringing them with you to your appointment.

If you're scheduled for an MRI you will also need to make sure your films are delivered here or you need to pick up a copy and bring them with you to your appointment. It is your responsibility to make sure your films are here. If you do not check and your films are not here you will not be seen that day.

If you're not sure if your films are here or not, you may call our x-ray department at 828-274-4555 and speak with Christy Pressley or Shannon.

I have read and accept the above medication and x-ray policies.

Patient Name: (Printed) ___________________________________

Patient Signature: ____ Date: _____________

Witness Signature: _______________________________________ Date: _____________

Southeastern Sports Medicine, P.L.L.C.
AUTHORIZATION for RELEASE of MEDICAL INFORMATION

Patient Information:

Name of Patient ______________________________ Date of Birth ________________

Address ____

City __________________________ State ________________ Zip _________________

Southeastern Sports Medicine, P.L.L.C., 59 Turtle Creek Drive, Asheville, NC 28803

The above named business is authorized to disclose protected health information.

Check all that apply:

__________ Leave information at my home. Telephone # _________________________

☐ Appointment information ☐ Lab/x-ray/ results ☐ Billing and Insurance information
☐ Any medical information ☐ Other: ___________________________________

__________ Leave information at my work. Telephone # _________________________

☐ Appointment information ☐ Lab/x-ray/ results ☐ Billing and Insurance information
☐ Any medical information ☐ Other: ___________________________________

__________ Leave information on my cellular phone. Telephone # ________________

☐ Appointment information ☐ Lab/x-ray/ results ☐ Billing and Insurance information
☐ Any medical information ☐ Other: ___________________________________

__________ Leave information with the following person/persons __________________

____ Telephone # ___________________

☐ Appointment information ☐ Lab/x-ray/ results ☐ Billing and Insurance information
☐ Any medical information ☐ Other: ___________________________________

Explanation/Findings of X-rays and MRIs

To assist your physician in fully explaining the results of your diagnostic x-rays or MRIs, your physician may show you your films. This may occur in an open area and may be overheard by others. A private review may be scheduled if you wish.

_______ I agree Signature: **__________________________________ Date: ____________**

_______ I disagree Signature: **__________________________________ Date: ____________**

Southeastern Sports Medicine
7 Turtle Creek Drive
Asheville, North Carolina 28803
828-274-4555 Office
828-274-8348 Fax

Keith M. Maxwell, MD
Daniel T. Eglinton, MD
Andrew Rudins, MD
Jerome L. Pettit, PA-C
Gregory S. Motley, MD
Lauren D. Brock, PA-C
Richard Jones, MD
Jonathan Swinger, PA-C

PAYMENT OF ACCOUNTS

NO INSURANCE INFORMATION:

If you do not have your insurance cards available at the time of your appointment, you will be considered self-pay and payment will be expected at time of service.

NO INSURANCE:

If you do not have insurance, payment is expected at time of service. A minimum of $140.00, excluding any x-rays, injections, or procedures is expected at check in. We realize that injuries are unexpected and money is not always available. If the full amount cannot be paid at time of service, then prior arrangements must be made with the Patient Accounts Department.

We do not accept or file liability insurance. If you have a claim which you are filing with liability, we will be happy to give you a receipt showing your payment. You may file this for your re-imbursement.

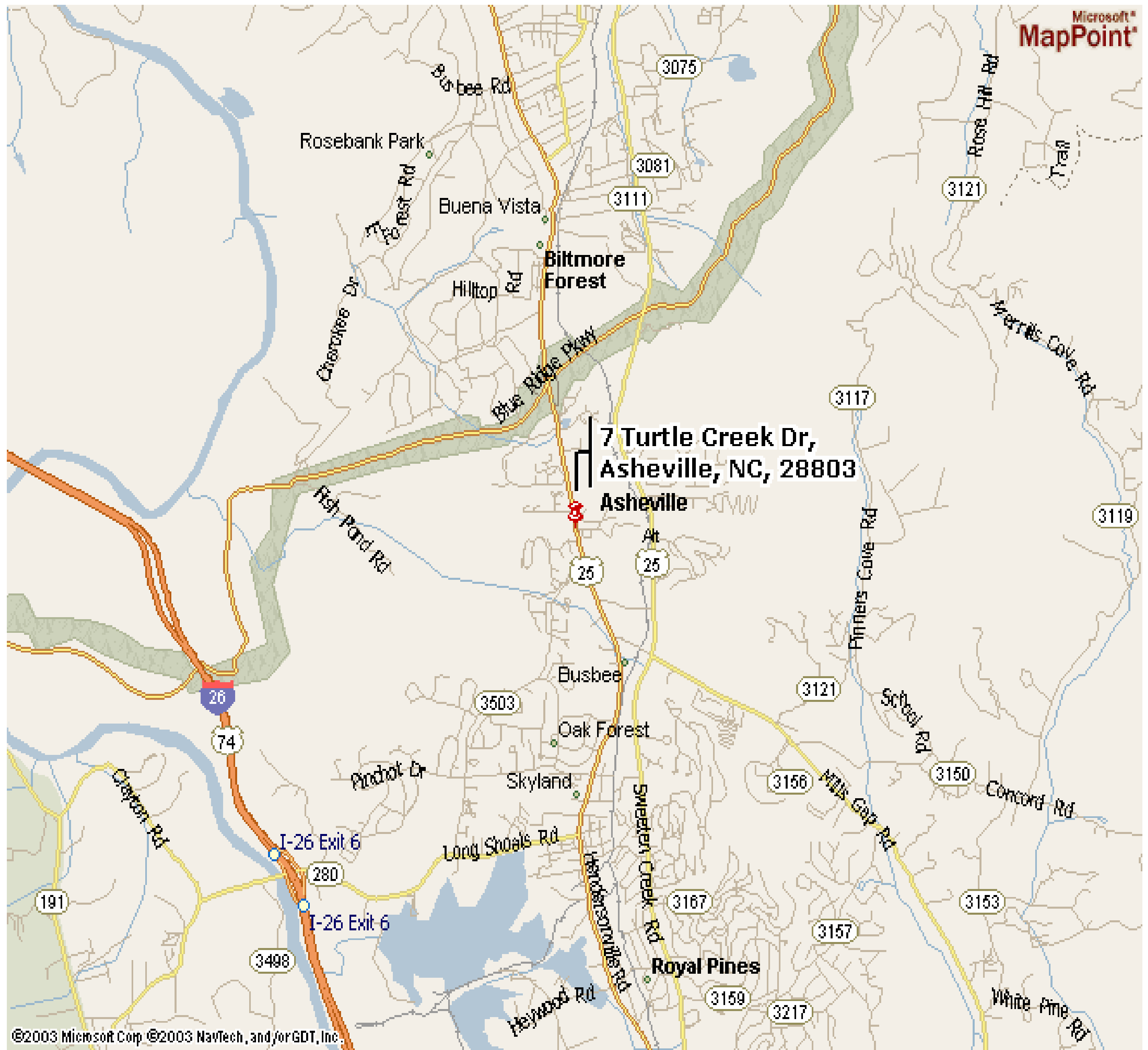
____
PATIENT AND/OR RESPONSIBLE PARTY

____
DATE

____
WITNESS

THANK YOU FOR YOUR CO-OPERATION.

Southeastern Sports Medicine
Map to Asheville Office



If you have any questions please call our office at 828-274-4555