

NEW PATIENT INFORMATION

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Please print, complete and bring this form to your first visit, along with your photo ID, insurance card(s), a list of your medications, and any X-ray/MRI images (disc) and reports. You will also complete a brief electronic check-in when you arrive. Please print clearly.

1. PATIENT INFORMATION

Last name		First name		M.I.	Preferred name		Date of birth (MM/DD/YYYY)	
Street address		Apt / Unit		City		State		ZIP
Mobile phone		Other phone		Email		Best way to reach you ☐ Call ☐ Text ☐ Email		
Emergency contact name		Relationship		Emergency contact phone		Sex: ☐ Male ☐ Female		
Primary care physician		Referred by (doctor, friend, website, etc.)		Preferred pharmacy (name and location)				
Occupation		Sports / main activities		Dominant hand: ☐ R ☐ L				

2. INSURANCE (please also bring your card(s))

Primary insurance company		Member ID		Group #	
Policyholder name (if not the patient)		Policyholder date of birth		Relationship to patient	
Secondary insurance company (if any)		Member ID		Group #	

Is this visit related to: ☐ Work injury (workers' comp) ☐ Auto accident ☐ Other injury claim / legal case ☐ No

Claim # (if applicable) Date of injury Adjuster or attorney name and phone (if applicable)

3. REASON FOR YOUR VISIT

Area: ☐ Shoulder ☐ Elbow ☐ Wrist/Hand ☐ Hip ☐ Knee ☐ Ankle/Foot ☐ Other _____ **Side:** ☐ Right ☐ Left ☐ Both

Briefly describe your main problem (chief complaint)

When did it start? (date) How did it start? (specific injury, sport, fall, gradual onset, etc.)

Pain today (circle): 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain, 10 = worst)

Treatment so far: ☐ None ☐ Rest/ice ☐ Medications ☐ Physical therapy ☐ Injection(s) ☐ Brace ☐ Prior surgery on this area

Imaging done: ☐ X-ray ☐ MRI ☐ CT ☐ None Where / when: _____

Is this a second opinion? ☐ Yes ☐ No Previous doctor: _____

4. HEALTH SNAPSHOT (full history is completed at check-in)

Allergies to medications or latex (list, or write "none")

Taking blood thinners? ☐ Yes ☐ No

Current medications (or bring a list)

Prior surgeries (type and year)

Check any that apply: ☐ Diabetes ☐ High blood pressure ☐ Heart disease ☐ Prior blood clot ☐ Smoke / vape ☐ Pregnant or may be

Patient (or parent/guardian) signature

Printed name

Date