CARY ORTHOPAEDICS
& spine specialists

NEW INJURY/ISSUE FORM

NAME _____ Chart No. _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE #'s (home)_____ (cell) _____ (work) _____

EMAIL ADDRESS _____

DATE OF BIRTH _____ EMPLOYER _____

RACE _____ ETHNICITY _____ LANGUAGE _____

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____

EMERGENCY CONTACT PHONE # _____

PRIMARY CARE DOCTOR _____

PHARMACY (name & location) _____ HEIGHT _____ WEIGHT _____LBS

1. List Body Part(s)/ Briefly describe discomfort _____

Right ____ Left ____ Bilateral (both) ____

2. On a scale of 1-10 what is your pain right now? _____

3. What date did this problem/pain begin? (approximately) MO/DAY/YEAR _____

4. Is this problem due to an injury? **YES** or NO **If yes go to 4a.**

4a. Where did the injury occur? (football field, grocery store, home, etc) _____

4b. What were you doing when the injury occurred? (walking, falling, playing) _____

4c. Was the injury due to the following? military activity__ volunteer __ student __ student athlete __ leisure activity __

5. Will you be filing though Workers Compensation, AUTO insurance, or Liability Insurance? **YES** or NO

5a. If **YES,** please give details (names, phone #'s, claim #'s, etc) _____

I hereby authorize the designated physician to release any information acquired in the course of my treatment to my insurance company for completion of claims. In consideration of the medical services to be rendered, I agree to pay to Cary Orthopaedic & Sports Medicine Specialists the regular charges for said services. I understand that I am responsible for all charges not paid by insurance. If applicable, I also request payment of government benefits either to myself or to the party who accepts assignment. I certify that I have read the above or had it explained to me and I agree to all of its terms and as evident of this fact sign my name below.

CONSENT FOR CARE: I, the undersigned, do hereby agree and give consent for Cary Orthopaedic Sports and Spine Specialists and/or Performance Physical Therapy to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical condition. (Patient Name)

Signature of Patient/Guardian/Legal Representative Date Staff Initials