University Orthopaedic Clinic and Spine Center

PLEASE SIGN IN

Date _____ Arrival Time _____ Physician _____ Med Rec # _____

Patient Name _____ DOB _____

Today's Visit: ☐ Recheck ☐ New Problem ☐ PreOp ☐ Post Op ☐ Injection ☐ Supply/Cast Change

What are we seeing you for today? ☐ Left Side ☐ Right Side ☐ Both Sides Body Part _____

☐ Left Side ☐ Right Side ☐ Both Sides Body Part _____

Please make sure you complete the information below accurately, as we will not go back and change symptom or accident dates unless you have not been seen for this problem before.

If today's visit IS NOT a recheck for something we have treated in the last 6 months, please check one of the following:

☐ Re-Injuiry on something we've treated in the past. How long ago? MO _____ DAY _____ YEAR _____

If New Injury or Re-Injury, Date **NEW** injury occurred MO _____ DAY _____ YEAR _____

Injury Occurred at ☐ Job ☐ Home ☐ Auto ☐ School ☐ Athletic Injury ☐ Business ☐ Other _____

If New Symptom, Date you first noticed **NEW** Symptoms MO _____ DAY _____ YEAR _____

Has your Address, Phone Number or Insurance changed since your last visit? ☐ YES ☐ NO

Have you signed up for Insurance through the Exchange? ☐ YES ☐ NO

Please provide the name of your Primary Care Physician so we can send referral notes: _____

If you have not provided this before: Cell # _____

If you have not provided this before: Email Address _____

_____

Signature of Patient or Responsible Party

For Office Use Only:

Body Part _____ Body Part _____ Body Part _____

DOI or DOS _____ DOI or DOS _____ DOI or DOS _____

DFS _____ DFS _____ DFS _____

POA _____ POA _____ POA _____

T N AX F D P

1 2 4 5 6 9 1001 1003 1004 1005 PCP _____

University Orthopaedic Clinic PC complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of Race, Color, National Origin, Age, Disability, or Sex. (DISCLOSURE ADDED 10/12/2016)