

Lake Placid Sports Medicine, PLLC
Patient Medical History

Patient "Preferred" Name: _____ DOB: _____ Age: _____

What Orthopaedic problem are you here for? _____

Please Circle which side: Left Side Right side

How did this problem start? _____

Date of Injury/Illness?(This must be answered) _____

Have you had this problem before?: Yes or No
If yes, when? _____

Have you been treated by another physician for this? Yes or No
If yes, by whom? _____

Name/Address of family physician: _____

Do you have any disabilities: Yes or No
If yes, please state: _____

What Insurance is to be billed? _____

Is this Work Comp or No Fault Related? YES or NO

Please update current insurance with receptionist!!!

Patient's occupation: _____

Driver's License#: _____

Name/Phone# of Pharmacy: _____

Has our practice seen you or any family member in our office before? Yes or No

If family member, please list names: _____

Are you left or right hand dominant? _____

Maiden name: _____

Medical Release

The undersigned hereby authorizes and requests Lake Placid Sports Medicine, PLLC, in accordance with said policies and laws, to release confidential information for the purpose of medical care, insurance payment, and disability determination.

(Signature of patient/guardian)

DATE: _____