POCATELLO ORTHOPAEDICS & SPORTS MEDICINE INSTITUTE

Date _____

Reason for Treatment _____ Date of Injury, or 1st symptom _____/_____/_____

☐ Male

Patient's Legal Name: Last _____ First _____ Middle _____ ☐ Female

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Age _____ D.O.B. _____

Work Phone _____ Ext. _____ S.S. # _____ Marital Status: M ☐ S ☐ D ☐ W ☐

Race _____ Language _____ Ethnicity _____

Patient's Employer _____ Occupation _____

Spouse's Name _____ D.O.B. _____ Employer _____

Work Phone _____ Occupation _____

May we contact you by email: ☐ No ☐ Yes Email: _____

Father's Name (IF PATIENT IS A MINOR) _____ S.S. # _____ D.O.B. _____

Father's Home Address: _____ City, State, Zip _____ Phone _____

Father's Employer _____ Work Phone _____

Mother's Name (IF PATIENT IS A MINOR) _____ S.S. # _____ D.O.B. _____

Mother's Home Address _____ City, State, Zip _____ Phone _____

Mother's Employer _____ Work Phone _____

Whom May We Contact In Case of Emergency? _____

Relationship _____ Phone _____

Who referred you to our Practice? ☐ Family/Friend ☐ ER ☐ Physician: **(Please note below)** ☐ Yellow pages

_____

PRIMARY INSURANCE COMPANY NAME _____

Subscriber Name _____

Subscriber D.O.B. _____ I.D. No. _____ Group No. _____

SECONDARY INSURANCE COMPANY NAME _____

Subscriber Name _____

Subscriber D.O.B. _____ I.D. No. _____ Group No. _____

Please list medications you are currently taking, including dosage & strength (include over the counter):
