

Acute / Chronic

New Patient Intake Form
Dr. J. Richard Steadman

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever seen Dr. Steadman? No Yes If Yes, when? \_\_\_\_\_

Referred by: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Ref. Contact #: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Fax: \_\_\_\_\_

Occupation: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

Email address: \_\_\_\_\_

Which Knee: LEFT RIGHT BOTH: L>R L<R

Date of Injury: \_\_\_\_\_

What is/are your Diagnosis(es) and/or symptoms? Location of pain? What aggravates or alleviates pain?

Have you had prior surgery on your knee(s)? NO YES If yes, when and what procedure? \_\_\_\_\_

X-Rays: No Yes Within 6 months? \_\_\_\_ Date: \_\_\_\_\_ Sending for Review: \_\_\_\_ Will Bring: \_\_\_\_

MRI: No Yes Within 6 months? \_\_\_\_ Date: \_\_\_\_\_ Sending for Review: \_\_\_\_ Will Bring: \_\_\_\_

Faxing reports: MRI \_\_\_\_ Surgery \_\_\_\_ Other \_\_\_\_\_

Name of Insurance Company? \_\_\_\_\_

PLEASE FAX MRI/SURGICAL REPORTS AND COPY OF INSURANCE CARD TO 970-479-5813
ATTN: CRISTAL

OFFICE USE ONLY

O Registration Faxed/e-mailed

O Office Visit Only

O Entered into Computer

O Office Visit with Surgery

O Re-Activated and Updated in Computer

O Ordered from DOCUVAULT storage Date Requested: \_\_\_\_/\_\_\_\_/\_\_\_\_

Additional Notes: \_\_\_\_\_