WELCOME TO OUR OFFICE

PATIENT NAME_____ Date_____

MALE/FEMALE DATE OF BIRTH_____ AGE_____

ADDRESS_____CITY_____

STATE_____ZIPCODE_____HOME PHONE_____

CELL PHONE_____EMAIL_____

SOCIAL SECURITY#_____OCCUPATION_____

HEIGHT_____WEIGHT_____SHOE SIZE_____

MEDICATIONS_____

ALLERGIES_____ TOBACCO USE: YES NO

PAST SURGICAL HISTORY_____

FAMILY DOCTOR_____PHONE#_____

FAX#_____ADDRESS_____

WHO REFERRED YOU TO OUR OFFICE?_____

WHAT IS YOUR MAIN CONCERN TODAY_____

_____

TYPE OF ATHLETE:_____

NAME & LOCATION OF SCHOOL_____

COLLEGE-name & location_____

RECENT ATHLETIC/ACADEMIC ACCOMPLISHMENTS:_____

_____

PROFESSIONAL ATHLETE-team name & location_____

ATHLETIC TRAINERS NAME_____

I hereby give my permission to Dr Lee S Cohen Associates to administer the proper care necessary in the diagnosis and treatment of my condition. I understand I am financially responsible to Dr Lee S Cohen Associates for any balance that my insurance carrier does not pay. A copy of this signature is as valid as the original.

X_____DATE_____

THANK YOU FOR FILLING OUT THIS FORM AND CONGRATULATIONS FOR TAKING TIME TO INVEST IN YOURSELF!!!!!!