Medical Profile

Today's Date: ____ / ____ / _____

Patient Name: _____ Patient Age_____

(First)   *(Last)*

Home Address: _____

Street   City   State   Zip Code

Phone - Home: (_____) _____ - _____ Cell: (_____) _____ - _____ Email Address: _____

Date of Birth: ____ / ____ / _____ SS#: _____ **Gender:** Male   Female   Decline to answer   Other _____

Occupation: _____ Work: (_____) ____ - _____ Current Height: _____ Current Weight: _____

Patient Symptoms and Injury Questions

Body part(s) involved (*please indicate L or R if applicable*):

_____

How/when did the problem begin? _____

Please list prior types/dates of treatment for this condition (*physical therapy, injection, surgery, etc.*):

Please list any other medical conditions you have: (*asthma, gastric reflux, migraines, diabetes, etc.*):

_____ _____

Referring Physician

Name: _____ Phone: (_____) ____ - _____ Address: _____

Please let us know how you heard about us!

At Meier Orthopedic Sports Medicine it is our goal to provide our patients with the best care possible. If you have had a less than satisfactory experience at our practice, we would like to request that you contact our office immediately so we can address the situation.

We encourage all patients to call or email our office with their concerns or suggestions for improvements so we can continue to improve our patient care. By contacting us directly, we are able to address your concerns in a much quicker and more personal manner.

Photo / Video Consent Form

I, _____, give my permission to allow Meier Orthopedic Sports Medicine to use my photos and/or video on the Internet and/or print material for educational and marketing purposes. I hereby release Meier Orthopedic Sports Medicine and Dr. Steven Meier from any and all claims and demands arising out of, on in conjunction with, the use of the photographs and/or video. Meier Orthopedic Sports Medicine need not approach me again for authorization on these photos and/or video. I am of legal age. I have read the foregoing fully and understand its contents.

SIGNED: _____ ____ / ____ / _____   _____ ____ / ____ / _____
            Patient Signature   Date   Dr. Steven Meier   Date