**Parkcrest Orthopedics**
*Specialist in Upper Extremities*
**James P. Emanuel MD, CIME**

**Patient Name: _____ Date of Birth:_____**

Primary Care Physician: _____ Referred By: _____

What body part are you being seen for today? _____

Specify side (circle one): Left Right Bilateral

How did your pain/problem start? (checkmark appropriate) O Injury O Spontaneous O Chronic

What was your date of injury/when did your problem start? _____

What is your current work status? (checkmark appropriate) O Full Duty O Light Duty O Off Work

Describe your symptoms: _____

_____

**Checkmark any treatments you've had for this problem.**

O None O Physical Therapy O Narcotic Medication O Massage or Ultrasound O Traction
O Braces O Surgery O Manipulation/Chiropractic O Visco Supplementation O Cortisone Injection
O Anti-Inflammatory Medication

**Checkmark any testing you've had for this problem:**

O Xrays O Bone Scan O MRI Scan O CT Scan O EMG/Nerve Conduction O Blood Work/Labs
O Venous Doppler Study

O Other: _____

**Height: _____ Weight: _____**

**Current medications/dosages:**

_____

_____

_____

**Immunizations:**

Date of your last Flu Vaccine? _____Date of your last Pneumonia Vaccine? _____

**Please list your specialty physicians:** (ex. pain management, cardiologists, rheumatologists, oncologists, etc.)

| Doctor name | Specialty | Doctor Name | Specialty |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |

***You must INITIAL ONE BOX below.***

☐ ***I do NOT have an open Workers' Compensation claim*** *pertaining to the above listed body part/injury. I do not intend to file a Workers' Compensation claim for the above listed body part/injury. I accept financial responsibility for any charges not covered by my medical insurance. By initialing this statement, I agree to these conditions and certify that this information is correct to the best of my knowledge.*

☐ ***I have an open Workers' Compensation claim*** *pertaining to the above listed body part/injury. My treatment/appointments are being authorized by my employer's Workers' Compensation insurance carrier or its other payor. By initialing this statement, I certify that this information is correct to the best of my knowledge.*

If you have filed a Workers' Compensation claim for the above listed body part at any time, and the claim has been denied and/or the case has been closed, then we require a copy of the denial letter and/or closure letter prior to your treatment in order for us to submit your charges to your private medical insurance.

*By signing below, I am stating that all of the above information is accurate to the best of my knowledge. I agree to the terms and conditions described above.*

X_____

**Sign** **Date**