



37 W Garden Street, Suite 103 / t 315.253.3291
Auburn, New York 13021-2663 / f 315.258.8759

Patient Information

Name _____ Soc. Sec.# _____ Date _____

Local Address _____ City _____ State _____ Zip _____

Permanent Address (if different) _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Age _____ Marital Status (circle) Married Single Other

Place of Employment _____ Work Phone Number _____

Spouse (or Parent) place of Employment _____ Phone Number _____

EMERGENCY CONTACT _____ Phone Number _____

Date of onset/injury/surgery _____ Primary Care Physician _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING: *check those that apply*

- Diabetes
- High Blood Pressure
- High Cholesterol
- Heart Disease/attack
- Pacemaker
- Headaches
- Kidney Problems
- Nervous Problems
- Hernia (type)
- Rheumatoid Arthritis
- Skin Sensitive to heat
- Skin Sensitive to cold
- Dizziness
- Cigarette Smoker
- Seizures
- Metal Implants
- Osteoporosis
- Pregnant
- Unexplained Weight Loss
- History of Cancer

Allergies: _____

 Other Conditions: _____

Previous Fractures or Injuries: _____

Previous Surgeries (dates): _____

Please explain any items from above that you have checked and provide approximate dates:

If you are on any medications, please list it and what it is for:

I hereby authorize Cayuga Orthopaedic and Sports Physical Therapy, P.C. to furnish the insurance company with full information regarding my treatment when so requested. (I understand I must sign a release if information is requested from a source not covered by the privacy policies.)

 Patient's signature

 Date



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