ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

NO-FAULT INTAKE FORM

NEW PATIENT

NAME	DATE OF BIRTH

IF THIS INJURY IS RELATED TO AN AUTO ACCIDENT, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

DATE OF INJURY/ACCIDENT		
WHICH PART(S) OF YOUR BODY WAS INJURED? ◯ LEFT ◯ RIGHT		
PRIOR TO THIS ACCIDENT, DID YOU HAVE A PROBLEM/PAIN IN THE AFFECTED AREA? ◯ YES ◯ NO		
DID YOU SUSTAIN OTHER INJURIES DUE TO THIS ACCIDENT? ◯ YES ◯ NO		
IF "YES", GIVE DETAILS (EX: LEFT HAND LACERATION)		
DID YOU HAVE IMMEDIATE PAIN OF THE AFFECTED AREA AT THE TIME OF THE ACCIDENT OR A FEW DAYS LATER? ◯ IMMEDIATE ◯ DAYS LATER (INDICATE NUMBER):		
WHERE DID INJURY OCCUR? (LOCATION)		
HOW DID INJURY OCCUR?		
DID YOU GO TO THE EMERGENCY ROOM? ◯ YES ◯ NO	IF "YES", WHERE?	DATE
DID YOU HAVE X-RAYS OR AN MRI? ◯ YES ◯ NO	IF "YES", WHERE?	DATE
WAS THIS ACCIDENT THE RESULT OF A THIRD PARTY? (THIRD PARTY IS SOMEONE OTHER THAN YOU, OR YOUR OWN PERSONAL MEDICAL INSURANCE THAT IS LIABLE FOR COSTS ASSOCIATED WITH YOUR INJURY/ACCIDENT). ◯ YES ◯ NO		
HAVE YOU BEEN TREATED BY ANOTHER HEALTH CARE PROVIDER FOR THIS INJURY? ◯ YES ◯ NO	IF "YES", GIVE DETAILS	
WERE YOU ◯ DRIVER ◯ PASSENGER ◯ PEDESTRIAN	DID THE AIR BAG DEPLOY? ◯ YES ◯ NO	
WHERE YOU WEARING YOUR SEAT BELT AT THE TIME OF THE ACCIDENT? ◯ YES ◯ NO	DO YOU HAVE A POLICE REPORT? ◯ YES ◯ NO	
ARE YOU BEING COUNSELED BY A LAWYER FOR THIS INJURY? ◯ YES ◯ NO	NAME OF ATTORNEY	

SIGNATURE (PERSON COMPLETING FORM)	DATE COMPLETED