

Acute / Chronic

New Patient Intake Form
Dr. J. Richard Steadman

Patient Name: _____ Date: ____ / ____ / ____

Have you ever seen Dr. Steadman? No Yes If Yes, when? _____

Referred by: _____ Home Phone: _____

Ref. Contact #: _____ Work Phone: _____

Age: _____ Cell Phone: _____

Date of Birth: ____ / ____ / ____ Fax: _____

Occupation: _____ Mailing Address: _____

Email address: _____

OV
ONLY

OV
OP

Which Knee: LEFT RIGHT BOTH: L>R L<R

Date of Injury: _____

What is/are your Diagnosis(es) and/or symptoms? Location of pain? What aggravates or alleviates pain?

Have you had prior surgery on your knee(s)? NO YES If yes, when and what procedure? _____

X-Rays: No Yes Within 6 months? ____ Date: _____ Sending for Review: ____ Will Bring: ____

MRI: No Yes Within 6 months? ____ Date: _____ Sending for Review: ____ Will Bring: ____

Faxing reports: MRI ____ Surgery ____ Other _____

Name of Insurance Company? _____

PLEASE FAX MRI/SURGICAL REPORTS AND COPY OF INSURANCE CARD TO 970-479-5813
ATTN: CRISTAL

OFFICE USE ONLY

Registration Faxed/e-mailed

Office Visit Only

Entered into Computer

Office Visit with Surgery

Re-Activated and Updated in Computer

Ordered from DOCUVAULT storage Date Requested: ____ / ____ / ____

Additional Notes: _____