Date: ____________________

791 West Genesee Street
Skaneateles, New York 13152
Tel: 315-685-7544 Fax: 315-685-7549
victorysportsmedicine.com

FOR INTERNAL USE ONLY
ACCT# ______________
CSR ______________

Welcome to our office. Please complete all entries, print the form and sign at the bottom.

Patient Information

Items marked with (*) are required by the Centers of Disease Control & Prevention (Federal Government) & required for Continuity of Care Documentation.

Patient's Last Name:			**First Name:**		**Middle Name:**
Nickname:	**Date of Birth:**	**Age:**	**Sex** ❑ M ❑ F	**Marital status:** ❑Single ❑ Married ❑ Divorced ❑Separated ❑Widowed	
Street address:		**P.O. Box:**	**City:**	**State:**	**Zip Code:**
Race: * ❑American Indian ❑Asian ❑African American ❑ Pacific Islander ❑White ❑Decline To Answer			**Language Preference:** * Primary______________ Secondary______________ ❑Decline to Answer		**Ethnicity:** * ❑Spanish or Hispanic ❑Non Spanish or Non Hispanic ❑Decline to Answer
If minor or college student, please enter names of both parents or guardian:					

Contact Information

Home Phone:	**Work Phone:**	**Cell Phone:**	**Email:**

Please Rank from 1 to 3 your preferred method of contact:

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact

Name:	**Relationship:**	**Telephone:**

Employment Information (if minor or college student, please enter parent or guardian's employment information)

Employer Name:		**Occupation:**	**Employer Telephone:**	**Years Worked:**
Employer Street Address:	**P.O. Box:**	**City:**	**State:**	**Zip Code:**

School Information (if student in grade K-12 or college, please provide the following information)

School / College Name:	**Grade / Level:**	**School/College Telephone:**	
Street Address:	**City:**	**State:**	**Zip Code:**

Primary Care Physician (if none, please leave blank)

In order to facilitate your care, we will send a copy of your records to your primary care physician. If you would like us to contact you for approval prior to sending to your primary care physician, please check here ❑

Primary Care Physician Name:		**Telephone:**	
Street Address:	**City:**	**State:**	**Zip Code:**

Referring Medical Provider (if you were referred to us by a medical provider other than your primary care physician please enter below)			
Referring Medical Provider Name:		**Telephone:**	
Street Address:	**City:**	**State:**	**Zip Code:**

Pharmacy		
Name:	**Location:**	**Telephone:**

Primary Insurance Information (Please provide your insurance card at the time of check-in for your appointment)			
Insurance Company Name:	**Member/Subscriber/Identification #:**		**Group #:**
Name of Insured (Policy Holder):	**Date of Birth:**		**Relationship to Patient:** ❑Self ❑Spouse ❑Child ❑Other

Secondary Insurance Information (Please provide your insurance card at the time of check-in for your appointment)			
Insurance Company Name:	**Member/Subscriber/Identification #:**		**Group #:**
Name of Insured (Policy Holder):	**Date of Birth:**	**Social Security #:**	**Relationship to Patient:** ❑Self ❑Spouse ❑Child ❑Other

School, Work, Automobile or other Third Party Liability Claim? (Please indicate below if your injury occurred at school, at work, from an automobile accident or is related to a third party liability claim)			
❑ School Related	❑ Work Related Please ask for workers comp injury report form	❑ From a Motor Vehicle Accident Please ask for motor vehicle injury report form	❑ Related to Third Party Liability Claim Please note we currently do not accept third party liability cases

How did you hear about Victory Sports Medicine & Orthopedics?	
❑ Family / Friend / Relative (list name)	❑ TV Commercial
❑ Victory Sports Medicine Employee (list name)	❑ Newspaper
❑ Physician / MD / DO (list name)	❑ Yellow Pages
❑ Other Healthcare Provider (list name)	❑ Website
❑ Coach /Athletic Director (list name)	❑ Search Engine (i.e. Google)
❑ Workers Comp. / Case Manager (list name)	❑ Street Sign
❑ Sports Team (Specify):	❑ Other (Specify):

Very Important: Please bring insurance cards, X-Rays, MRIs and any other notes relating to your office visit.

I certify that the above information is complete and true to the best of my knowledge.

Signature of Patient or Authorized Representative

Date

Print Name