WELCOME TO OUR OFFICE

PATIENT NAME____DATE____________

MALE/FEMALE DATE OF BIRTH______________ AGE__________

ADDRESS__________________________ CITY_______________________________

STATE________ZIPCODE___________HOMEPHONE_____________________________

CELL PHONE_____________________EMAIL___________________________

SOCIAL SECURITY#__________________________

OCCUPATION_____________________________SPORT PLAYED____________________

HEIGHT________WEIGHT__________SHOE SIZE______________

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?______________________________

WHAT IS YOUR MAIN CONCERN TODAY?____

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TYPE OF ATHLETE :

RECREATIONAL ____

MIDDLE SCHOOL -name & location____

HIGH SCHOOL - name & location____

COLLEGE - name & location____

PROFESSIONAL ATHLETE - name & location____

ATHLETIC TRAINER'S NAME____

I hereby give my permission to Dr Lee S Cohen Associates to administer the appropriate care necessary in the diagnosis and
treatment of my condition. I understand I am financially responsible to Dr Lee S Cohen Associates for any balance that my insurance carrier does not pay. A copy of this signature is as valid as the original.

X____ DATE_________________________

THANK YOU FOR FILLING OUT THIS FORM AND CONGRATULATIONS FOR TAKING TIME TO INVEST IN YOURSELF!!!!