ORTHOPAEDIC ASSOCIATES OF ZANESVILLE, INC.
SPORTS MEDICINE ZANESVILLE
2854 Bell Street, Zanesville, OH 43701
Phone: (740) 454-3273 Fax: (740) 588-1081

TODAY'S DATE: _____

REFERRING PHYSICIAN'S NAME: _____

PHYSICIAN'S PHONE:_____FAX:_____

PATIENT'S NAME:_____

PATIENT'S BIRTHDATE:_____

TELEPHONE NUMBER(S) TO CONTACT PATIENT:_____

PATIENT'S INSURANCE CO(s):_____

IF THE PATIENT HAS MEDICAID:

BILLING ID#:_____ and/or SSN #:_____

BODY PART(s):_____

HAS ANY DIAGNOSTIC TESTING BEEN DONE? (XRAYS/MRI/EMG) ☐ YES ☐ NO

IF SO, WHAT: _____

***(Please have patient bring actual films and report for any tests not performed in Genesis Healthcare System)***

HAS ANOTHER SPECIALIST BEEN SEEN FOR THIS BODY PART? ☐ YES ☐ NO

ANY PREFERENCE WHICH ORTHO IS SEEN? _____

ANY SCHEDULING REQUESTS (SUCH AS DAY OF WEEK/TIME OF DAY)? _____

_____

**For Orthopaedic Associates/Sports Medicine Zanesville:**

APPOINTMENT: DATE: _____TIME:_____

(Please ask patient to arrive 15 minutes early for appointment.)

ORTHOPAEDIC TO BE SEEN:_____