HUGH A. FREDERICK M.D., NEW PATIENT INFORMATION

Have you seen Dr. Frederick previously as a patient? _____ If so, when? _____

Patient's Full Legal Name:
(Last, first, middle, nickname)

Birthdate:	Age:	Social Security#	Drivers License #	State:

Street Address: (*Street, City, State, Zip)*

Telephone & area code: Home:	Work:

Employer:	Occupation:

Male Female	Marital status S M W D S	Spouse	Bus. Telephone for Spouse

Email Address:
(providing your email will allow you access to your medical record on line through our website; it will not be given out or used for any marketing)

If the patient is a minor, please complete the following.

Father's name	Street address, City, State, Zip	Telephone
Father's employer	Occupation	Bus. Telephone
Mother's Name	Street address, City, State, Zip	Telephone
Mother's employer	Occupation	Bus. Telephone
EMERGENCY CONTACT:	*Name and Phone of Relative, Friend or Neighbor*	

DEMOGRAPHICS: *Although this has nothing to do with the reason you are here and nothing to do with the treatment you will receive, this is now REQUIRED INFORMATION we must submit to the Federal Government. Please fill this out or just write decline on each line.*

Ethnicity: (Ex: Italian, French, Canadian)

Race: (Ex: Caucasian, Hispanic, Asian)

Preferred Language:

PREFERRED PHARMACY:

Pharmacy phone number:

PLEASE HELP US HELP YOU!

If you will write your answers to the questions below yourself, you can help Dr. Frederick cover routine matters of your medical history so he can spend his time with you on details of your hand or upper limb problem. *Thank You!*

I was referred to this office by Doctor _____

I. CHIEF COMPLAINT

1. What is your major complaint? _____

   _____

2. How long has this been bothering you? _____
3. Which Side? Right _____ Left _____ Both _____ (Check One)
4. Are you right or left handed? _____
5. Was an injury involved? Yes _____ No _____

   If so, date of injury: Month _____ Day _____ Year _____

   If so, did it happen at work? Yes _____ No _____

CURRENT MEDICATIONS: Please include prescription and over the counter medicines -- including medication name, dose, and frequency. If you have a current medication list, we are happy to make a copy instead of having you fill out this portion of the form.

MEDICATION	DOSAGE	FREQUENCY