



**Paul A. Dowdy, M.D.**  
Board Certified in Orthopaedic Surgery  
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Surgery, Reconstruction of the Shoulder & Knee

## PATIENT INFORMATION

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**PLEASE PRINT**

TODAY'S DATE	AGE	DATE OF BIRTH	SOCIAL SECURITY #	AREA CODE & HOME PHONE #
<b>PATIENT NAME</b>		MIDDLE	LAST	
FIRST				
LOCAL MAILING ADDRESS		CITY	STATE	ZIP CODE
PERMANENT MAILING ADDRESS		CITY	STATE	ZIP CODE
EMPLOYER (if minor, parent info.)			AREA CODE & PHONE #	
SPOUSE/PARENT (if minor child)				
<b>MESSAGES REGARDING MY APPOINTMENT OR MEDICAL CONDITION MAY BE LEFT AT THE NUMBERS LISTED BELOW:</b>				
AREA CODE & PHONE #		AREA CODE & PHONE #		
<b>IN CASE OF AN EMERGENCY YOU MAY CONTACT THE LISTED PERSON(S) BELOW:</b>				
NAME _____		RELATIONSHIP TO PATIENT _____	NAME _____	
ADDRESS _____		RELATIONSHIP TO PATIENT _____		
ADDRESS _____		ADDRESS _____		
AREA CODE & PHONE # _____		AREA CODE & PHONE # _____		
<b>PATIENT CHIEF COMPLAINT</b>				
<b>PRIMARY INSURANCE INFORMATION</b>				
INSURED NAME		DATE OF BIRTH	GROUP #	ID #
INSURANCE NAME		CLAIMS ADDRESS		AREA CODE & PHONE #
<b>SECONDARY INSURANCE INFORMATION</b>				
INSURED NAME		DATE OF BIRTH	GROUP #	ID #
INSURANCE NAME		CLAIMS ADDRESS		AREA CODE & PHONE #
REFERRED BY/REFERRING PHYSICIAN				