THE HAND & WRIST CENTER
Specialists in diagnoses, rehabilitation and surgery

PATIENT REGISTRATION FORM

TELL US ABOUT YOURSELF: ☐ **ADULT** ☐ **MINOR** **TODAY'S DATE:** ____________________

LAST NAME: ______________________________ ***FIRST NAME:*** ______________________________

DOMINANT HAND: ☐ RIGHT ☐ LEFT DATE OF BIRTH: ____________________ AGE:________ SEX: ☐ MALE ☐ FEMALE

SOCIAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNERSHIP ☐ SEPARATED/DIVORCED ☐ WIDOW

ADDRESS: ____ APT/UNIT#: _____________

CITY: ______________________________ STATE:________________ ZIP CODE:________________

PHONE: (________) ____________________ CELL PHONE: (________)____________________

EMAIL (OPTIONAL): ______________________________

(*NECESSARY FOR BILLING PURPOSES):
*SOCIAL SECURITY#: ______________________________ I.D.# / DRIVER'S LICENSE#: ____________________ STATE: __________

EMERGENCY CONTACT NAME: ______________________________

PHONE: (________) ____________________ RELATIONSHIP: ______________________________

EMPLOYER NAME: ______________________________

ADDRESS: ____ SUITE#: _____________

CITY: ______________________________ STATE:________________ ZIP CODE:________________

PHONE: (________) ____________________ FAX: (________)____________________

OCCUPATION/TITLE: ______________________________

WERE YOU REFERRED TO OUR OFFICE? ☐ ***NO*** ☐ ***YES (IF YES, BY WHO?)***

NAME: ______________________________ TITLE: ______________________________

ADDRESS: ____ SUITE#: _____________

CITY: ______________________________ STATE:________________ ZIP CODE:________________

PHONE: (________) ____________________ FAX: (________)____________________

HOW WILL YOUR SERVICES BE PAID?

☐ CASH-PAY ☐ PPO INS. ☐ OUT OF NETWORK INS. ☐ WORKERS' COMP. ☐ MEDICARE ☐ HMO INS. ☐ OTHER

COMPLETE THE APPLICABLE PORTIONS OF THIS SECTION IF YOU ARE INSURED:

INSURANCE NAME: ______________________________ **INSURANCE CONTACT PERSON:** ______________________________

ADDRESS: ____

CITY: ______________________________ STATE:________________ ZIP CODE:________________

PHONE: (________) ____________________ FAX: (________)____________________

NAME OF INSURED: ______________________________ **INSURED'S DATE OF BIRTH:** ____________________

YOUR RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER: ______________________________

INSURED'S SOCIAL SECURITY NUMBER or SUBSCRIBER I.D#: ____________________ **PLAN GROUP NO.:** ____________________

DATE OF YOUR INJURY/ SYMPTOMS ONSET: ____________________ *WORKERS' COMP CLAIM NO.: ____________________

******IF YOU HAVE SECONDARY, TERTIARY, OR MORE, INSURANCE COVERAGE, PLEASE ASK OUR STAFF FOR A SECOND INSURANCE PAGE******

08-03-08 HWC