WELCOME TO OUR OFFICE
Loren J. Jensen M.D. Hand Surgery Associates LLC

Patient

Name (last, first, MI)_____M _____ F _____

Address_____Apt#_____City_____State____Zip_____

Home Phone_____Business Phone_____Other Phone_____

Date of Birth_____Age_____Soc Sec #_____Employer_____

Spouse, Parent or Guardian

Name_____ Employer of Spouse (or of parent for minor patient):

Address (if different)_____ _____

Phone (if different)_____

Notify in case of Emergency_____Relationship_____

Medical History

Injury or Problem You Are Being Seen For Today_____

Left or Right Side?_____

Date Injury/Symptoms Began_____

Hurt at Work?_____ Last Day Worked_____

Drug Allergies_____

Referred to This Office By_____

Names of Other Family Members Seen Here_____

Name of Regular Family Doctor_____

Primary Insurance Information (Required)

Name of Insurance Company_____

Address of Insurance Company_____

City_____State_____Zip_____

Subscriber Name_____

Subscriber/Policy/Claim#_____

Group/Plan #_____

Subscriber Date of Birth_____Sex_____

Home Phone_____SocSec#_____

Secondary Insurance Information (Optional)

Name of Insurance Company_____

Subscriber/Policy/Claim#_____

Group/Plan #_____

Name on Insurance Card_____

Address_____

City_____State_____Zip_____

Subscriber Date of Birth_____Sex_____

Home Phone_____SocSec#_____

Workman's Comp Information (Required for Work Injury)

Insurance Company Name_____

Address_____

Phone #_____

Claim #_____

Claims Manager Name_____

Auto/Other Accident Information (Required if third party is paying)

Insurance Company Name_____

Address_____

Phone #_____

Claim #_____

Lawyer name/address if applicable_____

_____

No Insurance?? Please ask for Payment Agreement Form

Assignment and Release**:** I hereby authorize my insurance benefits be paid directly to the physician. **I am financially responsible for any balance due, including the full amount if my insurance company refuses to pay benefit**. I also authorize the physician or insurance company to release any information required for this claim.

Signature:_____Date:_____