



**THE
HAND SURGERY
CENTER**

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**Hand Surgery Center
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Appointment/Today's Date:

IF YOU ANSWER YES TO ANY OF THE QUESTIONS LISTED BELOW, YOU MUST PROVIDE INSURANCE INFORMATION UNDER WORKER'S COMPENSATION OR MOTOR VEHICLE/NO FAULT.

DID THIS CONDITION OCCUR AS A RESULT OF YOUR EMPLOYMENT ACTIVITIES? () Yes () No

DID THIS INJURY/CONDITION OCCUR AS A RESULT OF A MOTOR VEHICLE ACCIDENT? () Yes () NO

INSURANCE INFORMATION REQUIRED FOR ANY WORKER'S COMPENSATION CONDITION/INJURY & MOTOR VEHICLE/NO FAULT CONDITION/INJURY:

NAME OF INSURANCE CARRIER: _____

BILLING ADDRESS: _____

TELEPHONE #: _____ FAX# _____

ADJUSTER: _____

CLAIM# _____

Date of incident: _____

Please note that a policy number is not a claim number. You must have a valid claim number in order to proceed with your appointment.

Date: _____ Patients Name: First _____ Last: _____

Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

Home Telephone # () _____ Cell Phone # () _____

Social Security Number: _____ Sex: M F

Date of Birth: _____ Age: _____

E-mail Address: _____

Emergency Contact Name, Telephone Number, & Relationship To The Patient:

Patient's Employer (Company Name): _____

Occupation: _____

Work Phone # () _____ Fax Number # () _____

Where would you like to be reached for any medical reasons? () _____

Insurance Policy Holder Name (if other than patient):

First: _____ Last: _____

Relationship to the Patient: _____ Date of Birth: _____

S.S. # _____ Phone Number: _____

Employer/Company Name: _____

How Long Have You Been Having This Problem (Approximately)?

Which is the affected area? () Right () Left () Both

Are you right hand dominant () or left hand dominant ()

Who referred you to this office? _____

Referring Dr. _____ PCP: _____

Address: _____

City, Street, ZIP: _____

Phone Number: _____

Do you want a report to go to the referring physicians? Yes or No

Please note that due to HIPAA laws we cannot provide any information to relatives or friends without your written authorization. Is there anyone you authorize this office/M.D.

to release or discuss your medical record with? Yes or No

If the answer is yes please provide their information below.

Name, Telephone Number, & Relationship to the Patient:
