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

PATIENT REGISTRATION FORM

TODAY'S DATE: _____

WHAT ARE WE SEEING YOU (THE PATIENT) FOR TODAY? _____

DATE OF INJURY OR ONSET OF SYMPTOMS: _____

IS THIS MEDICAL CONDITION (OR INJURY) DUE TO ANY OF THE FOLLOWING: *Please speak with our staff if you check "YES" to any below.

WORK-RELATED? ☐ NO ☐ YES **MOTOR VEHICLE ACCIDENT?** ☐ NO ☐ YES **OTHER 3RD PARTY LIABILITY?** ☐ NO ☐ YES

***PATIENT'S* LAST NAME:** _____ ***PATIENT'S* FIRST NAME:** _____

***PATIENT'S* INFORMATION:**

DATE OF BIRTH: _____ AGE: _____ ***SEE STAFF FOR MINOR CONSENT FORM** GENDER: ☐ MALE ☐ FEMALE

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

ADDRESS: _____ APT/UNIT#: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (_____) _____ CELL PHONE: (_____) _____ WORK PHONE: (_____) _____

E-MAIL: _____ **Note: Please read disclaimer in the **Release of Information Authorization Form.

(ENTER THE GUARANTOR SOCIAL SECURITY NUMBER/INFO BELOW IF THE PATIENT IS A MINOR; OTHERWISE ENTER THE PATIENT'S)

*SOCIAL SECURITY#: _____ I.D.# / DRIVER'S LICENSE#: _____ STATE: _____

***PATIENT'S* EMERGENCY CONTACT (NAME):** _____

PHONE: (_____) _____ RELATIONSHIP: _____

***PATIENT'S* EMPLOYER NAME:** _____ ☐ **NOT EMPLOYED**

ADDRESS: _____ SUITE#: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: (_____) _____ FAX: (_____) _____

OCCUPATION/TITLE: _____

WAS THE PATIENT REFERRED TO OUR OFFICE? ☐ ***NO*** ☐ ***YES (IF YES, PLEASE COMPLETE BELOW)***

NAME: _____ TITLE: _____

PHONE: (_____) _____ FAX: (_____) _____

HOW WILL THE PATIENT'S SERVICES BE PAID?

☐ CASH-PAY ☐ **PPO INS.**** ☐ **MEDICARE**** ☐ WORKERS' COMP. ☐ OTHER: _____

****GIVE YOUR INSURANCE CARD TO OUR RECEPTIONIST AND COMPLETE THE FOLLOWING IF YOU ARE NOT THE PRIMARY INSURED:***

NAME OF PRIMARY INSURED (as registered with the plan): _____

INSURED'S ADDRESS: _____

INSURED'S SOCIAL SECURITY NUMBER: _____ **INSURED'S DATE OF BIRTH:** _____

SUBSCRIBER I.D#: _____ **GROUP NO.:** _____

YOUR RELATIONSHIP TO THE PRIMARY INSURED: ☐ SPOUSE ☐ CHILD ☐ OTHER: _____