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 YOUR INJURY OR ONSET OF SYMPTOMS: _____

LAST NAME: _____ ***FIRST NAME:*** _____

DATE OF BIRTH: _____ AGE:_____ 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__.

(*NECESSARY FOR BILLING YOUR INSURANCE PLAN):

*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, PLEASE COMPLETE BELOW)***

NAME: _____ TITLE: _____

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

HOW WILL YOUR SERVICES BE PAID?

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

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GIVE YOUR INSURANCE CARD TO OUR RECEPTIONIST

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****COMPLETE THE FOLLOWING IF YOU ARE __NOT__ THE PRIMARY INSURED:***

NAME OF PRIMARY INSURED (AS REGISTERED WITH THE INSURANCE CO): _____

INSURED'S ADDRESS: _____

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

INSURED'S SUBSCRIBER I.D#: _____ **PLAN GROUP NO.:** _____

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