

Hand Therapy Solutions, P.C.

Patient Registration Form

Please Print PATIENT'S SOCIAL SECURITY # _____ PATIENT'S E-MAIL: _____

PATIENT'S NAME _____ SEX _____ DATE OF BIRTH _____ AGE _____
(FIRST) (MIDDLE INITIAL) (LAST)

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE # () _____ MARITAL STATUS [] SINGLE [] MARRIED [] DIVORCED [] WIDOWED [] SEPARATED
(DAY OR EVENING)

EMPLOYER _____ OCCUPATION _____ WORK PHONE # () _____
(DAY OR EVENING)

EMPLOYER'S STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

RESPONSIBLE PARTY _____ HOME PHONE # () _____ RELATIONSHIP _____
(FIRST) (MIDDLE INITIAL) (LAST) (DAY OR EVENING)

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

NAME OF SPOUSE / NEXT OF KIN _____ HOME PHONE # () _____ RELATIONSHIP _____
(FIRST) (MIDDLE INITIAL) (LAST) (DAY OR EVENING)

SPOUSES / NEXT OF KIN EMPLOYMENT _____ WORK PHONE # () _____
(DAY OR EVENING)

PLEASE LIST ANY DRUG SENSITIVITIES OR ALLERGIES: _____

REFERRING PHYSICIAN _____ PCP / FAMILY PHYSICIAN _____

ACCIDENT INFORMATION [] AUTO
DATE OF ACCIDENT/INJURY: ___/___/___ [] OTHER:
TIME OF ACCIDENT ___:___ [] AM [] PM _____
DATE YOU FIRST SOUGHT TREATMENT: ___/___/___
TIME YOU FIRST SOUGHT TREATMENT ___:___ [] AM [] PM
IN WHICH STATE DID ACCIDENT OCCUR?

WORKMAN'S COMPENSATION INFORMATION
IS THIS A WORK-RELATED INJURY OR ILLNESS? [] YES [] NO
NAME OF WC CONTACT AT WORK: _____ PHONE # _____
DATE OF ACCIDENT / INJURY: _____ TIME OF ACCIDENT / INJURY: _____
DATE YOU FIRST SOUGHT TREATMENT: _____ TIME YOU FIRST SOUGHT TREATMENT: _____

INSURANCE INFORMATION
PRIMARY INSURANCE _____ ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____
POLICY # _____ GROUP# _____ SUBSCRIBER NAME _____ RELATIONSHIP _____
SECONDARY INSURANCE _____ ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____
POLICY # _____ GROUP# _____ SUBSCRIBER NAME _____ RELATIONSHIP _____

PAYMENT AND AUTHORIZATION INFORMATION
Your Insurance company will be billed for covered services, and any unpaid balance will be the responsibility of the patient or responsible party. Parents or guardians are responsible for payment with regards to a minor. The balance of the account will be due and payable if the Insurance company has not paid **within 45 days or if Worker's Compensation has not paid within 60 days.**
I hereby authorize Hand Therapy Solutions, Inc., to release medical information to the Insurance company (ies) listed above. Also by my signature and copies thereof, I authorize payment directly to Hand Therapy Solutions, Inc., of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. If my account is turned over to an attorney for collection, I will be responsible for all attorney fees which are usually 28% of the unpaid balance.

SIGNATURE _____ DATE _____