Hand Therapy Solutions, Inc.

Patient Registration Form

Please Print

PATIENT'S SOCIAL SECURITY #__________ ____________ _________

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 RHONE # ( )___________________
(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: ___ ; ____ [ ]AM [ ]PM
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