Welcome To Our Office

Cell # _____

New Patient Information

Date _____

PATIENT'S NAME (PLEASE PRINT) (FULL NAME)	S.S.#	BIRTHDAY	AGE	SEX		MARITAL STATUS				
				M	F	S	M	W	D	SEP

STREET ADDRESS PERMANENT TEMPORARY	CITY AND STATE	ZIP	HOME PHONE

PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	BUS. PHONE EXT.

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP

CONTACT PERSON'S NAME IN CASE OF EMERGENCY	PHONE

SPOUSE OR PARENTS NAME	SS #	BIRTHDATE

SPOUSE OR PARENT'S EMPLOYER'S	EMPLOYER'S STREET ADDRESS	BUS. PHONE EXT.

SPOUSE'S STREET ADDRESS (IF DIVORCED OR SEPARATED)	CITY AND STATE	ZIP	HOME PHONE

NAME AND ADDRESS OF REFERRING PHYSICIAN	NAME AND ADDRESS OF PRIMARY CARE PHYSICIAN (FAMILY DR.)

PLEASE COMPLETE THIS SECTION (EVEN IF WORKMANS COMP.) AND PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST.

PERSON RESPONSIBLE FOR PAYMENT	STREET ADDRESS, CITY, STATE	ZIP	HOME PHONE

PRIMARY INSURANCE CO. NAME	CERTIFICATE #	GROUP #

POLICYHOLDER'S NAME	POLICYHOLDER'S BIRTHDATE

SECONDARY INSURANCE CO. NAME	CERTIFICATE #	GROUP #

SECONDARY INS. POLICYHOLDER'S NAME	SECONDARY INS. POLICYHOLDER'S BIRTHDATE

WHAT ARE YOU SEEING THE DOCTOR FOR TODAY?	DATE OF ONSET	DESCRIPTI0N OF PROBLEM OR INJURY

IF THIS IS A WORK RELATED INJURY (PLEASE FILL OUT THIS SECTION)	BRIEF DESCRIPTION OF HOW ACCIDENT HAPPENED

NAME OF EMPLOYMENT WHERE INJURY HAPPENED?	COMPLETE ADDRESS OF THAT EMPLOYER

WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO STATE _____	DATE OF ACCIDENT	NAME OF ATTORNEY

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES AND COPAYMENTS REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE PERSONNEL.

VERY IMPORTANT: IF THIS IS YOUR FIRST VISIT PLEASE BRING IN XRAY'S, MRI'S AND ANY OFFICE NOTES RELATING TO TODAY'S VISIT.

PLEASE TURN PAGE OVER, READ, AND SIGN.

THIS FORM MUST BE SIGNED BEFORE TREATMENT IS INITIATED. THANK YOU.

Please remember that your insurance coverage is a contract between you and your insurance carrier. It is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed amounts for certain procedures and others pay only a percentage of the charge. It is your responsibility to pay the deductible amount or any other amount not paid for by your insurance.

In order to control our cost of billings, we request that our charges for office visits be paid for at the time of each visit.

If this account is assigned to an attorney as in a liability case, the patient is still responsible for payment of services rendered at the time services are performed.

PLEASE READ THE FOLLOWING AND SIGN BELOW:

I authorize disclosure of my medical records to my insurance company or attorney to facilitate payment and/or processing of my claim. I also authorize release of my medical history and/or records to any health care provider to whom I may be referred for a second opinion, for a consultation, for therapy or for treatment. I also authorize obtaining any medical records from health care providers involved in my treatment.

I understand that I am financially responsible for all charges unless treatment is covered by a health maintenance organization or Worker's Compensation insurance.

I hereby assign all insurance benefits, medical, liability or otherwise to The Hand Center of Greensboro for any unpaid portion of my bill.

SIGNED:_____ DATE: _____

I do consent to and grant permission for photographs, video filming or other visual aids to be taken during the course of my treatment and during any surgical procedures performed in the course of my treatment.

SIGNED:_____ DATE: _____

WITNESS: _____