The Hand Center – Patient Information Form (*To Be Completed by the Patient)*

Patient Number: _____ **Provider:** _____

Last Name: _____ **First Name:** _____ **MI:**_____

Address: _____ **City:** _____ **State:** _____

Zip Code: _____ **Social Security Number:** ____/____/____ **Date of Birth:** ____/____/____

Home Phone: (____) _____-_____ **Work:** (____) _____-_____ **Cell:** (____) _____-_____

Permission to leave message about your appointments: Home: ☐ Y ☐ N Work: ☐ Y ☐ N Cell: ☐ Y ☐ N

☐ **Male** ☐ **Female** **Marital Status:** _____ **Spouse's Name:** _____ (If applicable)

Email Address: _____ **Patient Employer:** _____

Race *(Circle one):* Hispanic Caucasian Black Native American Native Hawaiian Pacific Islander Asian Asian Pacific American Subcontinent Asian American Indian/Pakistani American Indian or Alaska Native Black-Non-Hispanic White-Non-Hispanic Other More than one race

Ethnicity *(Circle one)*: Latino/Hispanic Asian Black or African American White Jewish Other

Preferred Language *(Circle one)*: English Spanish French Polish Other: _____

Preferred Pharmacy: _____ Address: _____

PERMISSION IS GIVEN TO RELEASE MEDICAL AND FINANCIAL INFORMATION TO THE FOLLOWING PERSON(S):

Parent/Guardian Name (If patient is a Minor): _____ **Phone:** (____) _____-_____

Address: _____ ☐ **Check here if address is the same as patient's**

Emergency Contact (If different from Parent/Guardian): _____

Phone: (____) _____-_____ Address: _____

PERMISSION IS GIVEN TO RELEASE MEDICAL INFORMATION TO THE FOLLOWING PERSON(S):

Referring Physician: _____ Phone: (____) _____-_____

Address: _____ Fax: (____) _____-_____

Primary Care Physician: _____ Phone: (____) _____-_____

Address: _____ Fax: (____) _____-_____

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Hartford Orthopaedic Plastic & Hand Surgeons, Inc. d/b/a The Hand Center's Notice of Privacy Practices (NPP). By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the NPP.

X _____ ____/____/____ Patient Refused signature: _____

Patient or Parent/Guardian's Signature Date Office use only

As a subspecialty practice, the providers at The Hand Center work to advance the science, technology and treatment of the hand. As a result, your provider may have a financial interest in the surgery center where your surgery takes place or in the devices used in your treatment. We will continue to work to develop the best treatment practices for our patients.

X _____ _____/_____/_____

Patient or Parent/Guardian's Signature Date

I understand that The Hand Center may obtain my prescription history from a centralized database to assist in my care and I authorize The Hand Center to do so.

X _____ _____/_____/_____

Patient or Parent/Guardian's Signature Date

Insurance Information

Patient Name: _____ **Patient Number:** _____

Health Insurance Company (1): _____

ID Membership Number: _____ Group Number: _____

Subscriber name: _____ Date of Birth: _____ SSN: _____

Subscriber Address: _____

Patient's Relationship to Subscriber: _____

Subscriber Employer: _____

Employer Address: _____ City: _____ State/Zip: _____

Health Insurance Company (2): _____

ID Membership Number: _____ Group Number: _____

Subscriber name: _____ Date of Birth: _____ SSN: _____

Subscriber Address: _____

Patient's Relationship to Subscriber: _____

Subscriber Employer: _____

Employer Address: _____ City: _____ State/Zip: _____

Worker's Compensation/Liability Insurance Company/MVA: _____

Date of Injury: _____ Claim/File Number: _____

Claims Adjuster's Name: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

Employer at Time of Injury: _____

Occupation: _____ Years employed in this position: _____

IF YOU HAVE AN ATTORNEY REPRESENTING YOU FOR AN INSURANCE OR LEGAL CLAIM:

Attorney's Name: _____ Address: _____ City: _____

State: _____ Zip: _____ Phone: (____) _____-_____ Fax: (____) _____-_____

- *I understand that it is my responsibility to be familiar with the terms of my insurance policy and that I cannot assume my policy covers everything. Charges that may not be covered or that may be subject to a deductible include, but are not limited to, the purchase or rental of equipment, supplies and orthotics/splints.*
- *By signing this form I understand that I am responsible for obtaining a referral to Hartford Orthopaedic Plastic & Hand Surgeons, Inc. d/b/a The Hand Center (THC) if my insurance requires one. If no referral is obtained, I will be responsible for payment of services rendered.*
- *I authorize THC to release all necessary information to my insurance company and attorney in order to expedite payment of my claim. I assign benefits to THC on my behalf. I further understand that I am responsible for paying any balance not covered by my insurance and to inform THC of any new or different insurance coverage.*

X _____ _____/_____/_____

Patient or Parent/Guardian's Signature Date