Florida Hand Center

Name (last, first, initial): _____ D.O.B: _____ SS #: _____
Home phone: _____ Work Phone: _____ Cell Phone: _____
Mailing Address: _____
City: _____ State: ____ Zip: _____

Patient's Employer, Occupation, Address & Phone:
_____
_____

Marital Status: _____ Spouse Name: _____ Employer: _____

Ethnicity **(Please circle one of the following):** DECLINED HISPANIC/LATINO NOT HISPANIC/LATINO

Emergency Contact Name/Phone/Relation: (**Please add to HIPAA form)** _____

Is this problem due to an accident? (Please circle) AUTO WORK OTHER Date: _____
If work related please inform office staff.

Family Physician & Fax Number: _____

Are you currently residing in a Skilled Nursing Facility or Hospice? (Please circle) YES NO

Local Pharmacy Name & Location: _____
Phone Number: _____ Fax Number: _____

I authorize the doctors of Florida Hand Center to release any information concerning my care to the insurance company. I also understand that payment is due at the time of each visit and I am fully responsible; as my insurance is a contract between myself and the insurance company. I also authorize the release of information to any agency necessary for the payment on the account. I authorize Florida Hand Center to release records to any doctor and/or medical facility that they deem pertinent to my care.
I consent to any and all treatments recommended by the physicians at Florida Hand Center.

Signature: _____ Date: _____

****If this visit was NOT caused by accident or injury as described below, please put "NOT APPLICABLE" and SIGN** the bottom of this form, for insurance purposes this portion must be completed**

Many insurance companies write requesting account details after we send the claim. Please indicate if your problem is the result of an Automobile accident or injury. Work related accident or injury or Third Party Liability accident or injury. If you feel that your problem is work related in any way, please advise us at the first visit. This will help us make sure your claim is filed properly from the beginning. Answer the following questions and explain how this occurrence/accident/injury occurred.

Date of Accident/Occurrence/Injury_____
Place of accident: _____
Name of property owner: _____
Describe how accident occurred: _____

Signature: _____ Date: _____

Completion of this form will expedite payment of your medical bills. Thank You!