PATIENT PROFILE

HAND SURGERY ASSOCIATES OF LI, P.C. DOCTOR_____

PATIENT INFORMATION

Name _____ Patient ID_____

Address _____ DOB _____SS#_____

City/State _____Zip Code_____ E-Mail Address:_____

Primary Phone: _____ Home ( ) Work ( ) Other ( ) Alternate Phone: _____ Home ( ) Work ( ) Other ( )

Family Physician _____ Referring Physician _____

Emergency Contact_____ Phone #_____

Insured information (if different from patient information)

Name _____ Patient ID_____

Address _____ DOB _____SS#_____

City/State _____ Zip Code_____ E-Mail Address_____

Primary Phone: _____ Home ( ) Work ( ) Other ( )Alternate Phone: _____ Home ( ) Work ( ) Other ( )

Is your current injury work related? Yes ( ) No ( )

Is your current injury related to a motor vehicle accident? Yes ( ) No ( )

If yes, Date of Accident _____

Primary Insurance

( ) Same as Patient ( ) Same as Insured

Insurance Company _____ Patient ID#_____

Insured Relationship to Patient ( ) Self ( ) Spouse ( ) Child ( ) Other _____

Secondary Insurance

( ) Same as Patient ( ) Same as Insured

Insurance Company _____ Patient ID#_____

Insured Relationship to Patient ( ) Self ( ) Spouse ( ) Child ( ) Other _____

Financial Agreement

( ) I understand that my doctor does not participate in my insurance plan. My financial responsibilities have been explained to me. I **do not** assign benefits to the provider.

( ) I do not have insurance. My financial responsibilities have been explained to me.

( )My doctor is participating in my insurance. In Medicare/Other Insurance company assigned cases, the physician agrees to accept the charge determination of insurance carrier as the full charge. The patient is responsible only for the deductible, coinsurance, copayment, and non covered services as indicated by the insurance carrier. I assign all benefits to be paid directly to the provider.

Consent for treatment & release of record

( ) I consent to treatment necessary for the care of the above named patient. In addition I authorize the release of all medical records to the referring & family physicians and my insurance company, via fax, if applicable.

SIGN HERE

Signature _____ **Date**_____