Hand Therapy Specialists, Inc.

Patient Name:____ Preferred Name:___________________________
Last First MI

Birth date:___/____/____ Age:____ Sex: ☐ M ☐ F Marital Status: ☐Single ☐Married ☐Divorced ☐Separated
☐Widowed

Address:____
City State Zip

Phone:_____________________________ ________________________________ _____________________________
Home Work Ext Cell

SSN:________-_______-__________ E-mail:____

I would like appointment reminders by: ☐ E-mail *Or* ☐ Text; Carrier (i.e. Verizon/ATT):_____________________

Emergency Contact: ____ _____________________________
Name Relationship Phone

Name of Spouse (Parent if Minor):______________________________________ Birth date :____/____/_____

Spouse's Employer:____ Work Phone:_____________________

EMPLOYMENT

Occupation:_____________________________________ Employed:☐ Full ☐ Part-time ☐ Not Working ☐ Student

Name of Employer:_________________________________ Employer Phone:__________________________________

Employer Address:____
City State Zip

HISTORY

Date of Injury/Onset of Symptoms:_________________________________ Surgery Date:______/_____/_______

Involved Side: ☐ Right ☐ Left ☐ Both Are you: ☐ Right handed ☐ Left Handed

Injured: ☐ Shoulder ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Thumb ☐ Index ☐ Middle ☐ Ring ☐ Small

Current Work Status: ☐ Regular Duty ☐ Light Duty ☐ Not Working ☐ Retired ☐ Other:_________________

Describe how and where your injury/condition occurred:____

____

____

____

____

Referring Physician:____ Phone:__________________________

Primary Care Physician:____ Phone:__________________________

Medicare Recipients ONLY

Are you living at: ☐ Home ☐ Assisted Living ☐ Skilled Nursing Facility ☐ Adult Foster Care Home

Are you currently receiving Home Health Care? ☐ No ☐ Yes; If yes, start date:_____________________

Do you have an open: ☐ Auto Claim ☐3rd Party Liability Claim ________________________________

INSURANCE INFORMATION

Primary Insurance:____

ID#:______________________________ Group:____________________

Insured's Name:______________________________ Birth date:_____/_____/_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Significant Other ☐ Parent ☐ Other:______________

Insured's Employer:________________________ Work Phone:________________

Secondary Insurance:____

ID#:______________________________ Group:____________________

Insured's Name:______________________________ Birth date: _____/_____/_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Significant Other ☐ Parent ☐ Other:______________

Insured's Employer:________________________ Work Phone:________________

☐ **Auto** or ☐ **Third Party Insurance** ________________________________

Insured's Name:__________________________ Claim #:____________________

Adjuster:______________________________ Phone:____________________

Accident Occurred in: ☐ OR ☐WA ☐ Other:_____ Were you? ☐ Driver ☐ Passenger ☐ Bicyclist ☐ Pedestrian

Third Party Accident Occurred: ☐A Home ☐ A Business ☐ Other:______________________

Attorney:_________________________ Phone:________________________

Other Parties Insurance:____

Insured's Name:__________________________ Claim #:____________________

Workman's Compensation Insurance:____________________________________

Claim is: ☐ Accepted ☐ Deferred ☐ Closed, but being reopened ☐ Denied, but in appeal

Claim #:____________________________ Injury occurred in: ☐ OR ☐WA ☐ Other:________

Adjuster:______________________________ Phone:____________________

Attorney:______________________________ Phone:____________________

Employer at time of injury:____________________ Phone:____________________

Print Patient Name: Date