Hand and Reconstructive Surgeons, Inc.

New Patient Registration Form

Date

Please enter your information into this PDF, print, and bring with you to your appointment.

Patient Information

Field	
Full Name	
Address	
City	
State	
ZIP	
Telephone	
SSN	
Sex	M F
Birthdate	
Age	
Marital Status	Single Married Widowed Divorced
Emergency Contact Name, Relationship, and Telephone	
Referring Dr.	
Family Dr. Address and Telephone	
Employer Name, Address, and Telephone	

Responsible Party
(if different from patient)

Field	
Full Name	
Address	
City	
State	
ZIP	
Telephone	
SSN	
Sex	M F
Birthdate	
Age	
Relationship to Patient	
Employer Name, Address, and Telephone	

Patient Medical Information

Field	
Known Allergies	
Does the Patient Smoke?	
Current Medications	

Hand and Reconstructive Surgeons, Inc.

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Insurance Information

Primary Carrier	
Subscriber	
Policy #	
Group #	
D.O.B.	
(310) Primary Insurance Address	

Secondary Carrier	
Subscriber	
Policy #	
Group #	
D.O.B.	
(310) Secondary Insurance Address	

Date of Injury	
Description of the Condition	
Condition Related To:	Employment Auto Accident Other: ______________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES

SIGNATURE: ______________________________ DATE: ____________________

I HEREBY AUTHORIZE AND DIRECT MY INSURER TO ISSUE PAYMENT CHECK(S) FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY HAND AND RECONSTRUCTIVE SURGEONS, INC. TO BE MADE DIRECTLY TO THEM. REGARDLESS OF MY INSURANCE BENEFITS, IF ANY, I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED.

SIGNATURE: ______________________________ DATE: ____________________

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE MY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THE PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES TO THE PHYSICIANS OR ORGANIZATION FURNISHING THE SERVICE OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE TO PAYMENT TO ME. I REQUEST THAT PAYMENT UNDER THE MEDICAL INSURANCE PROGRAM TO BE MADE TO ME OR TO HAND AND RECONSTRUCTIVE SURGEONS, INC.

SIGNATURE: ______________________________ DATE: ____________________