

WASHINGTON HAND SURGERY

A Division of Proliance Surgeons, Inc., P.S.

Demographics

Patient Name: _____
(Last) (First) (Middle Initial) Nickname

Date of Birth: _____ Age: _____ Male / Female **Height:** _____ **Weight** _____ (Required)

Address: _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Home Phone: () _____ Cell Phone: () _____ Other: () _____

Single() Married() Divorced/Separated() Dependent() Parent/Spouse Name: _____

Primary Care Physician: _____ Referring Physician: _____

Current Employer: _____ Address: _____

Occupation: _____ Date last worked: _____

Reason for Consult

Are you Right or Left Handed: _____ Date of Injury/Onset of Pain(Required): _____

What part of the arm is bothering you R() L() _____

Is your pain/injury a result of an accident? Y N If yes, what type of accident: _____

Billing Information ****IN ORDER TO BILL YOUR INSURANCE, WE MUST HAVE A COPY OF YOUR CARD****

Name of person responsible for bill: _____

Address (if not as above): _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Work Phone: () _____

Is this a work related injury? (required) Y N If yes, did you file a Workers Comp Claim? Y N

Claim Number: _____ Name and Address of self insured company: _____

_____ Phone: () _____

PRIMARY INSURANCE

Ins. Co. Name: _____

Subscriber Name: _____

Date of Birth: _____

ID # _____ GROUP # _____

Subscriber's Employer: _____

ANY OTHER INSURANCE

Ins. Co. Name: _____

Subscriber Name: _____

Date of Birth: _____

ID # _____ GROUP # _____

Does your insurance carrier require a referral?: Y N If yes, it is your responsibility to obtain a referral from your primary care physician.

I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services furnished to me by any of the physicians at Proliance Surgeons. I authorize any holder of medical information about me to release to HCFA and its agents or to my other insurance any information needed to determine these benefits. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment and I accept financial responsibility for non-covered services.

Signature: _____ Date: _____