



**Personal Information**

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Gender (circle one): Male Female Marital status (circle one): Married Single Other

Emergency Contact \_\_\_\_\_ Emergency Contact Address \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Emergency Contact Phone ( ) \_\_\_\_\_

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**Insurance Information**

Primary Insurance \_\_\_\_\_ Type: HMO / PPO / POS / GROUP / MVA / WORK COMP

Secondary Insurance \_\_\_\_\_ Type: HMO / PPO / POS / GROUP / MVA / WORK COMP

Accident Related: None / Auto / Other \_\_\_\_\_

Employment Related: YES / NO Work Comp Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_

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**Injury Information**

Referring Physician \_\_\_\_\_ Date of Injury/Onset of Symptoms \_\_\_\_\_

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**Consent for Treatment**

I hereby give my consent to receive treatment and authorization to release payment and information. I request that payment of authorized insurance benefits be made either to me or on my behalf to The Hand Therapy Center of Omaha, Inc., for any service furnished by this provider, employed by the same. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related service.

**As a service to you, our office will bill all insurance. However, you are responsible for payment of your balance. Payment can be made at any time to our office. If you do not have insurance, payment is expected at the time of service.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

If you are 18 years of age or younger, a parent or guardian must sign this patient registration form on your behalf.

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**Office Use:** DX Code#1 \_\_\_\_\_ DX Code#2 \_\_\_\_\_ Area Treated \_\_\_\_\_