Hand Therapy Specialists, Inc.

Please fill out this form and print it from your computer. Bring it to your first appointment. Thank you!

Patient Name: _____ Sex: M ○ F ○ Age: ____ Date of Birth: _____
Last First MI

Home Address: _____ City: _____ State: ____ Zip: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell phone: _____

Social Security #: _____ Email Address: _____

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Employer: _____ Employed: Full /Part-time / Not Working / Student

Employer Address: _____ City: _____ State: ____ Zip: _____

Occupation: _____

Name of Spouse (Parent if Minor): _____ Birthdate: _____

Name of Employer: _____ City: _____ State: _____

Occupation: _____

Nearest Friend or Relative: _____ Phone: _____

Relationship: _____

Condition/Accident Information: (If applicable)

On the Job ○ Auto ○ (State:_____) Other: ○ (Home or School) _____

Date of Injury: _____ Body Part Injured: _____

How Injury occurred: _____

INSURANCE INFORMATION:

No Insurance ○ HTS, Cash Policy Form signed and understood ○

Primary Insurance: _____ Subscriber: _____

Subscriber Employer: _____ Subscriber DOB: _____

Subscriber Relationship to the Patient: _____ ID #: _____ Group #: _____

Secondary Insurance: _____ Subscriber: _____

Subscriber Employer: _____ Subscriber DOB: _____

Subscriber Relationship to the Patient: _____ ID #: _____ Group #: _____

Workmans' Compensation: Claim is: Open ○ Closed ○ Denied but in appeal ○ Deferred ○

Insurance Company: _____ Claim #: _____

Insurance Address: _____ Phone #: _____

Employer at the Time of Injury: _____ Phone #:_____

Motor Vehicle Accident: Insurance Company: _____

Name of Insured:_____ Claim #: _____ Policy #: _____

Insurance Address: _____ Phone #: _____

I authorize Hand Therapy Specialists, Inc. to furnish the above insurance company with any necessary information needed to process the claim. I also authorization said insurance to pay and assign all benefits to HTS, for all charges and billings for my therapy. The above information is true and correct.

Signature: _____ Date: _____