Welcome to our practice.

THE HAND CARE CENTER
SHOULDER AND ELBOW INSTITUTE
Orthopaedic Surgery / Surgery of the Hand
Plastic Surgery / Shoulder & Elbow Surgery / Sports Medicine

Account #_____

☐ DR. N GHALAMBOR ☐ DR. MUTZ ☐ DR. A. TALEISNIK ☐ DR. J. TALEISNIK ☐ DR. WILSON ☐ OT/PT

New Patient Information

Today's Date _____ Date of Injury _____ Appt. Date _____

Complaint _____ ❑ Right ❑ Left

Miss/Mrs./Ms./Mr. _____
Last Name First Name M.I. Maiden Name

Home Address _____
Street City & State Zip Code

_____/_____/_____ _____ _____ _____
Date of Birth Age Social Security Number Home Phone Number

Patient Status: ❑ Single ❑ Married ❑ Other Sex _____ ❑ Employed ❑ Full Time Student ❑ Part Time Student

School or Employer _____
Name Address Phone Number

_____
Patient Spouse / Parent / Guardian Address Phone Number

_____
Spouse / Parent / Guardian Employer Name and Address Phone Number

_____
Nearest Relative Not Living With You Phone Number

Are you ❑ Right Handed ❑ Left Handed Drivers License #_____

Referred by

DOCTOR'S NAME _____
Address _____
_____
Phone _____

❑ Friend _____
❑ Employer ❑ Yellow Pages
❑ Lawyer ❑ Insurance Company
❑ Relative ❑ Hand Care Center Employee
❑ Newspaper ❑ Sign in Front of Building

Insurance

Is your condition work related? ❑ Yes ❑ No Auto Accident? ❑ Yes ❑ No

Name of Worker's Compensation Carrier _____

Address _____
Street City & State

Have you filed your WKC Claim? ❑ Yes ❑ No

Insured's Name: _____
Social Security Number

_____/_____/_____ _____ _____
Date of Birth Sex Insurance Plan Name or Program Name

Is there another Insurance? _____ Insured's Name: _____
Name Social Security Number

_____/_____/_____ _____ _____
Date of Birth Sex Employer Phone Number

_____
Insurance Plan Name or Program Name

Authorization

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby assign THE HAND CARE CENTER SHOULDER AND ELBOW INSTITUTE to furnish to Insurance Carriers, including but not limited to Worker's Compensation carriers, employers, guardians, and Medicare or Medicaid, information concerning my illness and treatments, and I hereby assign to the Physician(s) all payments for medical services rendered tomyself or my dependents.

X _____ X _____
Date Patient's Signature (Parent/Guardian if patient is a minor)

FINANCIAL RESPONSIBILITY

I am responsible for all financial obligations of health services for the above patient, and for reimbursement and payment of claims from my insurance company. I understand that I am responsible for any amount not covered by insurance. If for any reason the account should become delinquent, I agree to pay for all collections and legal fees.

X _____ X _____
Date Patient's Signature (Parent/Guardian if patient is a minor)