HAVE YOU HAD OTHER THERAPY this year?
(Physical, Speech, Occupational, Chiropractic)
_____ Yes _____ No

MINOR PATIENT INFORMATION
(17 years & under)

____
Chart #

Patient name ____
Last First Middle Nickname

Address ____
(If you listed a P.O. Box above, list street address also)

City ________________ State ______ Zip ______ Age ______

Birth date ____________ Sex _____ Home phone (____)____________ Work phone (___) ____________

Child's Social Security # _____- ____ - ______ Which doctor referred you to us?____________

PARENT/GUARDIAN CHILD LIVES WITH

Parent/Guardian Name ____

Marital Status: Single _________ Married _________ Separated _________ Divorced _________ Widowed _________

Place of employment ____________________ Job Title/Function ____________________

Birth date ____________ Social Security # _____ - ____ - ______ Sex ______ Work Phone (____)__________

Name of Your Spouse______________ Spouse's Employer______________ Work Phone (____)__________

INSURED PARENT/GUARDIAN INFORMATION

Insured Parent/Guardian's Name ____________________ Insured's Social Security # _____ - ____ - ______

Insured's Address ____
(If you listed a P.O. Box above, list street address also)

City ______________ State _____ Zip ________ Insured's Home Phone (_____) ____________

Insured's Date of Birth ____________ Insured's Sex ______ Insured's Employer ____________

HAND/ARM Patients Only:
Injured/affected hand(s): Right ________ Left __________ Both ________
Which hand do you feed yourself with? R L Which hand do you write with? R L

Check type of injury: Workers Comp ______ Accident ________Auto _______ Other ____________

Date of injury/onset ______________ If auto accident, in which state did it happen? ____________

Statement of how accident happened ____

Attorney involved in this case (if applicable) ____________________ Phone # ____________

MEDICAL RELEASE AUTHORIZATION AND INSURANCE ASSIGNMENT

As parent or guardian, I hereby authorize HAND & REHABILITATION SPECIALISTS OF NORTH CAROLINA to furnish to the patient's physician, insurance company or attorney, any medical information regarding their illness/injury and treatment.

I assign to HAND & REHABILITATION SPECIALISTS OF NORTH CAROLINA, all payments from my insurance carrier for the patient's treatment. I also understand that I am responsible for full payment of all services rendered to the patient, regardless of insurance coverage, except in the case of an approved workers compensation claim.

Parent/Guardian Signature ________________________________ Date ____________