

**PATIENT INFORMATION**  
**(18 years & over)**

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

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 ( \_\_\_\_\_ ) \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Which doctor referred you to us? \_\_\_\_\_

If student: Full time \_\_\_\_\_ Part time \_\_\_\_\_ School/University \_\_\_\_\_

Marital status: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widow(er) \_\_\_\_\_

Name of your spouse \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Spouse's employer \_\_\_\_\_ Work phone ( \_\_\_\_\_ ) \_\_\_\_\_

Nearest relative (not living with you) \_\_\_\_\_ Relationship to you \_\_\_\_\_

Address \_\_\_\_\_ Home phone ( \_\_\_\_\_ ) \_\_\_\_\_

Your job title/function \_\_\_\_\_

Place of employment \_\_\_\_\_

Employment address \_\_\_\_\_  
Street Address City State Zip

**HAND/ARM** Injured/affected hand(s): Right \_\_\_\_\_ Left \_\_\_\_\_ Both \_\_\_\_\_  
**Patients Only:** 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 # \_\_\_\_\_

**COMPLETE ONLY IF COVERED BY WORKERS COMPENSATION**

Name of person at work to contact about insurance \_\_\_\_\_

Phone # ( \_\_\_\_\_ ) \_\_\_\_\_ Workers Comp insurance carrier \_\_\_\_\_

Address of carrier \_\_\_\_\_

**MEDICAL RELEASE AUTHORIZATION AND INSURANCE ASSIGNMENT**

*I hereby authorize HAND & REHABILITATION SPECIALISTS OF NORTH CAROLINA to furnish my physician, my insurance company (including Medicare) or my attorney, any medical information regarding my illness/injury and treatment.*

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

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

\* **How did you find out about us?**  Doctor  Friend/family  Asked to be treated here  Advertisement