



Name _____
LAST FIRST MIDDLE INITIAL

_____ Male _____ Female Social Security Number _____ Birth Date _____

Address: _____
STREET (REQUIRED) APT # CITY STATE ZIP CODE

Address: _____
MAILING (IF DIFFERENT FROM ABOVE) APT # CITY STATE ZIP CODE

Home Phone: _____ Work Phone: _____

Employer of Patient: _____

Should an emergency occur while you are at Seattle Hand Surgery, who should we contact? (other than your residence)

Name: _____ Phone: _____

Affected area _____ Date of injury or onset of symptoms _____

Is this visit for a job related injury or occupational disease? _____ Yes _____ No

Have you opened a Labor & Industries claim? _____ Yes _____ No If yes, claim # _____

If your employer at the time of injury is privately insured for work injuries, what is the name of the workers compensation company, address and claim number?

Name _____ Address _____

Claim # _____

If privately insured, please fill in the following information and present your insurance cards upon completion of this form to the reception desk.

Primary Insurance _____ Subscriber Name _____
NAME

Subscriber's Employer _____ Patient's Relationship to Subscriber _____

Subscriber's Birth Date _____ Subscriber's Address _____

Social Security Number _____ Birth Date _____

Policy # _____ Group # _____ Plan # _____

Secondary Insurance _____ Subscriber Name _____
NAME

Subscriber's Employer _____ Patient's Relationship to Subscriber _____

Subscriber's Birth Date _____ Subscriber's Address _____

Social Security Number _____ Birth Date _____

Policy # _____ Group # _____ Plan # _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy by the Notice by calling 206-292-6252, requesting one at this office, or on the web at www.seattlehand.com.

Signature Date
As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

Signature Relationship Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I AUTHORIZE THE SEATTLE HAND SURGERY GROUP, THE SEATTLE HAND REHABILITATION CLINIC, AND THE SEATTLE HAND SURGERY UNIT TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY OR MY DEPENDENT'S EXAMINATION OR TREATMENT ONLY TO THE AUTHORIZED INSURANCE CARRIER, LEGAL COUNSEL, OR REQUESTING PHYSICIAN.

ASSIGNMENT OF INSURANCE BENEFITS

I AUTHORIZE THE PAYMENT OF SURGICAL AND/OR MEDICAL BENEFITS TO BE MADE TO THE PHYSICIANS OF THE SEATTLE HAND SURGERY GROUP, THE SEATTLE HAND REHABILITATION CLINIC, AND THE SEATTLE HAND SURGERY UNIT FOR SERVICES RENDERED TO MYSELF OR MY DEPENDENTS COVERED UNDER MY INSURANCE. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ANY AND ALL MEDICAL BILLS INCURRED.

DATE SIGNED (Patient, or Parent or Guardian, if Minor)

DATE SIGNED (Patient, or Parent or Guardian, if Minor)