



**HAND AND MICROSURGERY ASSOCIATES INC.
COLUMBUS HAND THERAPY, LLC**

USE CAPS IF COMPLETING ON COMPUTER

Acct. #

**PATIENT INFORMATION – PLEASE PRINT CLEARLY
PLEASE COMPLETE BOTH SIDES OF FORM AND RETURN WITH INSURANCE CARDS TO THE RECEPTIONIST.**

Date:		Doctor <input type="checkbox"/> Dr. Cook <input type="checkbox"/> Dr. Kobus <input type="checkbox"/> Dr. Lubbers <input type="checkbox"/> Dr. Nappi <input type="checkbox"/> Dr. Gowda			Therapist		Date of Injury		
Patient Last Name			First Name		MI	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security #	
Patient Address				City		State		Zip Code	
Home # ()		Work # ()		Cell # ()		Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W		Date of Birth	Age
Employer Name			Employer Address		City		State		Zip Code
Emergency Contact Name			Relationship to Patient		Home # ()		Work # ()		Cell # ()

E-mail Address:

Referred By (Physician Name)				Family Physician (Primary Care Physician)						
Address				Address						
City		State		Zip		City		State		Zip
Phone # ()		Fax # ()		Phone # ()		Fax # ()				

WORKERS COMPENSATION (ONLY COMPLETE IF THIS IS WORK RELATED) IF THIS SECTION NOT APPLICABLE CHECK THIS BOX

Workers Comp Claim #		Date of Injury		Employer Name		Employer Phone # ()	
Employer Address			City		State		Zip Code
<input type="checkbox"/> Is Employer self insured				<input type="checkbox"/> Doesn't have Worker's Compensation Card			
Claim Status		DX Code	DX Code	DX Code	DX Code	DX Code	DX Code
MCO Name & Adjuster				POR Name			

INSURANCE INFORMATION (THESE SECTIONS MUST BE COMPLETED) PATIENT DID NOT HAVE CARD

Primary Insurance

Insurance Company Name			Subscribers Name			Relationship to Patient <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian		
Insurance Company Address			City	State	Zip Code	Date of Birth (if not patient)		Social Sec # (if not patient)
Subscriber ID #		Insurance Group #		Employer Name			Employer Phone # ()	
Employer Address			City		State		Zip Code	
<input type="checkbox"/> Did Not Know Employer Address								

Secondary Insurance

PATIENT DID NOT HAVE CARD

Insurance Company Name			Subscribers Name			Relationship to Patient <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian		
Insurance Company Address			City	State	Zip Code	Date of Birth (if not patient)		Social Sec # (if not patient)
Subscriber ID #		Insurance Group #		Employer Name			Employer Phone # ()	
Employer Address			City		State		Zip Code	
<input type="checkbox"/> Did Not Know Employer Address								

ATTORNEY INFORMATION (COMPLETE ONLY IF AN ATTORNEY REPRESENTS YOU)

IF THIS SECTION NOT APPLICABLE CHECK THIS BOX

Attorney's Name	Law Firm's Name	Phone # ()	Fax # ()
Address	City	State	Zip Code

RESPONSIBLE PARTY (COMPLETE ONLY IF RESPONSIBLE PARTY IS OTHER THAN PATIENT)

IF THIS SECTION NOT APPLICABLE CHECK THIS BOX

Last Name	First Name	Middle Initial	Relationship to Patient <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian	
Street Address	City	State	Zip Code	Social Sec #
Home Phone # ()	Work Phone # ()	Employer Name of Responsible Party		Birth Date
Employer Address of Responsible Party		City	State	Zip Code

NURSING HOME INFORMATION

If you are a Medicare patient living in a Nursing Home Check Here and write the Nursing Home Name/Address & Phone # in this Section.

Nursing Home Name	Phone # ()
City	State
	Zip

HOW WERE YOU REFERRED TO US?

Physician _____	Patient _____	Kiosk Add _____
Radio _____	Advertisement _____	Newspaper _____
Magazine _____	Other _____	Yellow Pages _____

Additional Person you wish us to share your Protected Health Information with.

Person's Relationship to You

Signature of Patient (or Responsible Party & Relationship if Other Than Patient) Patient Parent Legal Guardian

Date