Annapolis Hand Center

PATIENT INFORMATION SHEET

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City**: _____ **State:** _____ Zip: _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email: _____ **SS#:** _____ **Sex:** _____ **Marital Status:** _____

Guarantor Name: _____ **SS#:** _____ **Date of Birth:** _____

Emergency Contact: _____ **Emerg. Phone:** **H**: _____ **C**: _____

Primary Insurance: Circle: Work Comp / Auto Accident / Other Date of Injury: _____ State: _____

Primary Medical Ins: _____	**Secondary Medical Ins:** _____
Subscriber Name: _____	**Subscriber Name:** _____
Subscriber DOB: _____	**Subscriber DOB:** _____
Policy ID Number: _____	**Policy ID Number:** _____
Group Number: _____	**Group Number:** _____
Work Comp Ins: _____	**Auto Policy:** _____
Address: _____	**Address:** _____
City: _____	**City:** _____
State, Zip: _____	**State, Zip:** _____
Adjustors Name: _____	**Adjustors Name:** _____
Telephone Number: _____	**Telephone Number:** _____
Claim Number: _____	**Claim Number:** _____

Employer Name: _____ **Employer Telephone:** _____

Street Address:

City: _____ **State:** _____ **Zip:** _____

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services, co-pays, deductibles and/or insurance, I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the provider or a designated representative to contact me by telephone about appointments, billing, and medical care.
- I authorize the physician to release any medical information required to process this claim.
- I acknowledge that I have reviewed and been offered a copy of the "Notice of Privacy Practices".
- I authorize the disclosure of my protected health information to _____.
- I understand that a fee for no shows may apply.
- I have reviewed the information above and can attest that it is correct to the best of my knowledge.

Signature of Patient/Guarantor:_____ Date: _____