PATIENT REGISTRATION TODAY'S DATE__________

Patient Name	Date of Birth	Sex	Age
Parent if Patient is a Minor			
Patient's Social Security Number or last 4 numbers			
Home Address	City	State	Zip
Home Telephone Number	Work Telephone Number	Cell Number	
Occupation	Employer's Name		
Employer's Address	City	State	Zip
Spouse Name	Employer		
Primary Care Physician	**Primary Care Physician Phone Number**		
Referring Physician	Referring Physician Phone Number		

NOTIFY IN CASE OF EMERGENCY

Name	Relationship		
Address	City	State	Zip
Home Telephone	Work Telephone		

INSURANCE INFORMATION

Primary Insurance Name	Insurance ID No. (Contract/Group #)
Subscriber's Name	Subscriber's Date of Birth
Secondary Insurance Name	Insurance ID No. (Contract/Group#)
Subscriber's Name	Subscriber's Date of Birth

Were You Injured on the Job? YES NO Have you Informed Your Employer? YES NO
Is this visit related to an auto accident? YES NO **Please supply claim # and insurance information**

I **understand that the Center for Hand and Extremity Reconstructive, PLC will bill my health insurance, but that I am ultimately responsible for payment of services rendered that are not covered by my health insurance and any co-payments and/or deductibles.** I authorize release of any medical information necessary to process my insurance claims to the Center for Hand and Extremity Reconstructive Surgery, PLC and authorize payment of medical benefits to be made directly to Joseph M. Failla, M.D. for all services rendered.

PATIENT SIGNATURE:____**DATE:**______________

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