Hand Surgery Specialists of Nevada

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Patients Name: _____ DOB: _____ SSN: _____

Home Address: _____Apt ___ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Emergency Contact Name: _____ Relationship: _____Phone: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Race: ☐ Asian ☐ African American ☐ White ☐ Hispanic ☐ Other

_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Patients Employer: _____ Employer Phone: _____

Employers Address: _____ City: _____ State: _____ Zip: _____

If the patient is a minor under the age of 18, are you the legal guardian? ☐ Yes ☐ No
If not, who is? _____ Phone: _____
Relationship: _____
Who were you referred by: _____ Phone: _____

Work Related Injury: ☐ Yes ☐ No Auto Accident: ☐ Yes ☐ No Date of Injury: _____

Advanced Directive: ☐ Yes ☐ No Copy on File: ☐ Yes ☐ No Retired: ☐ Yes ☐ No

INSURANCE COVERAGE:

Primary

Insurance Company: _____
Address: _____
Phone: _____
ID#: _____
Group#: _____
Relation to Patient: ☐ Self ☐ Spouse ☐ Parent
Subscriber Name: _____
Subscriber Address: _____
Subscriber Employer: _____
Subscriber SSN# _____ DOB: _____
Pharmacy Preference: _____

Secondary

Insurance Company: _____
Address: _____
Phone: _____
ID#: _____
Group#: _____
Relation to Patient: ☐ Self ☐ Spouse ☐ Parent
Subscriber Name: _____
Subscriber Address: _____
Subscriber Employer: _____
Subscriber SSN# _____ DOB: _____
Phone: _____

Pharmacy Address: _____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to Hand Surgery Specialists of Nevada Young LLP dba Hand Surgery Specialists of Nevada. We will gladly file your insurance claim, however, payment for co-pays and deductibles are required at the time services are rendered. We cannot guarantee payment to Hand Surgery Specialist of Nevada. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will become responsible to all amounts not covered payable to Hand Surgery Specialists of Nevada. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency.
I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records if necessary.

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____