Hand Care Specialists of Wesley Chapel, LLC

Date: _____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST – FIRST – MIDDLE INITIAL)		ADDRESS	
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ☐Male ☐Female	MARITAL STATUS ☐Single ☐Married ☐Other_____
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)		EMPLOYER PHONE

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ☐spouse ☐parent ☐guardian

NAME (FIRST – LAST – MIDDLE INITIAL)		ADDRESS (if different from patient)		
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

Authorization to release health information to:

Name(s)		ADDRESS	
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:		AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ☐NEVER DATE:	

Release the following information:

☐All Records ☐Chart Notes ☐Radiology Reports ☐Operative Reports ☐History & Physicals

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

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PATIENT MEDICAL HISTORY

PATIENT NAME (LAST – FIRST – MIDDLE INITIAL)

***** Preferred Pharmacy:**

Allergies

☐ NONE/No Known Allergies ☐ Adhesive Tape ☐ Anesthesia ☐ Aspirin ☐ Codeine
☐ Dairy Products ☐ Iodine/Shellfish/Contrast Dye ☐ Latex ☐ Morphine ☐ Penicillin
☐ Sulfa Drugs ☐ Wheat

OTHER: Reaction:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Occupation: _____ ☐ Retired ☐ Disabled (reason _____)
☐ **Yes** ☐ **No -** Do you drink alcohol? ☐ Daily ☐ Weekly ☐ Infrequently ☐ Recovering Alcoholic
☐ **Yes** ☐ **No -** Do you use tobacco? ☐ Smoke (__ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

☐ NONE of the problems listed
☐ allergies
☐ anemia
☐ arthritis conditions
☐ asthma
☐ arterial fibrillation
☐ bleeding problems
☐ BPH
☐ CAD coronary artery disease
☐ cancer
☐ cardiac arrest
☐ celiac disease
☐ chest pain
☐ CHF congestive heart failure
☐ chronic fatigue syndrome
☐ depression
☐ diabetes
☐ drug/alcohol abuse
☐ erectile dysfunction
☐ fibromyalgia
☐ Gerd
☐ heart disease
☐ high cholesterol
☐ hyperinsulinemia
☐ hyperlipidemia
☐ hypertension
☐ hypogonadism male
☐ hypothyroidism
☐ infection problems
☐ insomnia
☐ irritable bowel syndrome
☐ kidney problems
☐ menopause
☐ migraines/headaches
☐ neuropathy
☐ onychomycosis
☐ organ injury
☐ osteoporosis
☐ pulmonary embolism/blood clot in legs
☐ seizure disorders
☐ shortness of breath
☐ sinus conditions
☐ stroke
☐ syndrome X
☐ tremors
☐ wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):
PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR