THE HAND CENTER

www.norfolkhandcenter.com

Patient Registration Form

Patient Acct #: _____

PATIENT

Patient's Name: Last	First *(legal)*:	Middle Initial:	
Address:			
City:	State:	Zip:	
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
SSN#:	Date of Birth:	Age:	
Home Phone #	Work #	Ext #	Cell #
Employer:	Occupation:		
Email Address:			

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unreported/Refused to Report

Race
☐ White
☐ Asian
☐ Pacific Islander
☐ Black/African American
☐ Native Hawaiian
☐ American Indian or Alaskan Native
☐ More than one race
☐ Unreported/Refused to Report

How would you like to receive appointment reminders?
☐ Postal ☐ Phone
☐ Portal

Preferred Language:
_____

Pharmacy Name: Street/City: Phone:

Mail Order Pharmacy Name: Phone:

Family Physician Name: _____ Phone: _____

Referring Physician Name: _____ Phone: _____

Emergency Contact Name: Phone: ☐ Home ☐ Work ☐ Cell

**** Please present your insurance card to the receptionist ****

INSURANCE

Primary Insurance: _____

Subscriber's Name: _____ DOB _____ SSN _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other

Secondary Insurance _____

Subscriber's Name: _____ DOB: _____ SSN: _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other

Has a Worker's Compensation claim been filed for this injury? ☐ Yes ☐ No If Yes, Date of Injury: _____

Nurse Case Manager Name & Phone: _____ Adjuster Name & Phone: _____

*Approval must be given by your employer, Nurse Case Manager or Adjuster **before** your appointment. All appointments made without prior approval will be rescheduled.

FINANCE

Responsible Party (for patients who are under age 18)

Name-Last:	First: (legal)	Middle Initial:
Address: (if different than patient)		
City:	State:	Zip:
SSN#:	Date of Birth:	
Phone #:	Relationship to patient: ☐ Father ☐ Mother ☐ Guardian	

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