

Welcome to Advantage Hand Therapy & Orthopedic Rehabilitation, LLC

PATIENT INFORMATION

Name _____ Social Security # _____ - _____ - _____

Date of Birth _____ Drivers License # _____

Address _____ City _____ State ____ Zip _____

Telephone _____ Work # _____ Marital Status _____ Sex M ___ F ___

E-mail address _____ (for internal use only)

Employer _____ Work Address _____

Responsible Party/Insured _____ Telephone _____

Social Security # _____ Employer _____

Work Address _____ Work # _____

Relationship to patient _____ DOB _____

REFERRAL INFORMATION

What Physician referred you to our clinic? _____

Primary Care Physician _____

EMERGENCY CONTACT INFORMATION

In case of emergency contact _____ Telephone _____

ACCIDENT INFORMATION

Part of the body injured _____ Injury Date _____ Surgery Date _____

Accident type: Work Comp ____, Auto ____, None ____, Other _____

If work comp do you have a case manager/rehab nurse following your care? _____

If so Name _____ Telephone _____

INSURANCE INFORMATION

Insurance Company _____ Telephone _____

Address _____ City _____ State ____ Zip _____

Policy # _____ Group # _____ Group Name _____

Insured Name _____ Birth Date _____

HMO _____ PPO _____ Other _____ Spoke with _____

DED _____ Met _____ PT Copay/Coins _____ Max Benefits/Visit limit _____