HAND & WRIST SURGERY OF NJ, LLC – WORKER'S COMP & MOTOR VEHICLE ACCIDENT- PATIENT INFO.

Last Name:___________________ First Name:____________________ M.I.:______ Age:_____

Address:___________________________ City:____________________ State:_____ Zip:______

Birth Date:________________ SS#:________________ E-Mail:__________________________

Sex:_____ Marital Status:________ Home Phone: __________________ Cell:_______________

Employer:____________________________________ E-Mail:___________________________

Employer Address:___________________________________ Employer Phone:_____________

How and where did accident occur?____

____

Date of Injury or Accident:____

Description of Problem(s):____

____

Previous Treatment:____

____

Family Physician Name & Address:____

Who referred you to us?:____________________ Address:________________________

Insurance Co. Covering Injuries:____

Insurance Co. Address:____

Claim #:____________ Adjustor:____________________ Telephone #:______________

Secondary Insurance:_____________________________ ID:______________________

Insured's Name:_____________________ Relationship to Pt:_______ Birthdate:______

I hereby authorize payment from the insurance company to be sent directly to Hand & Wrist Surgery of NJ, LLC for any service rendered to me by the group. I also authorize the release of medical information to my insurance company in order for Hand & Wrist Surgery of NJ, LLC to complete necessary forms. I am personally responsible for payment of bills, if my claim is denied (for any reason). I am responsible for any co-insurance amounts, non-covered charges, and any balance remaining after insurance payment to your office.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees will be given to me concerning the results of any treatment or operation. Dr. Steve Ugras will attempt to improve me over my present status but cannot guarantee to return me back to normal status.

Signature:____ Date:__________________