Hand and Upper Extremity Rehab, LLC

Patient Registration Form

PLEASE PRINT

Patient Demographic Information			
First Name		**Middle Initial**	**Last Name**
Social Security Number	**Date of Birth**		**Gender**
			❑ Male ❑ Female
Marital Status		**Employment / Student Status**	
❑ Single ❑Married ❑Divorced ❑Widowed		❑Employed ❑Retired / Student ❑FT ❑PT	
Patient Home Street Address		**Patient City, State & Zip Code**	
Employer		**Employer Address**	

Patient Communication Information		
EMAIL CONSENT		
In order to be in compliance with HIPAA, we need your permission to communication via email.		
❑ I give HUER the permission to communicate with me via email, regarding treatment, statements and or appointments. _____ ☜ *place your initials on the blank line* ***(if you do not give your permission, do not check the box or put your initials)***		
Primary Email Address		
Secondary Email Address		
Home Telephone ( )	Work Telephone ( )	
Mobile Telephone ( )	Other Telephone ( )	

Referring Physician Information			
Name of Referring Physician			**Telephone Number**
			( )
Date of Surgery	**Type of Surgery**		**Diagnosis**
			❑Left ❑Right
PCP Info	**Name of Primary Care Physician**		**Telephone Number**
			( )

Emergency Contact Information		
Whom should we contact in case of an emergency:		**What is their relationship to you:**
		Other
Home Phone	**Work or Cell Telephone**	
( )	( )	

THIS FORM MUST ACCOMPANY THE INSURANCE / WORKER'S COMP INFORMATION FORM
Please give the receptionist a copy of all insurance cards and photo identification