(Office Use Only) Acct#:____________________Dr:_________________

CAROLINA HAND and SPORTS MEDICINE, P.A.

Christopher T. Lechner, M.D. | Bruce I. Minkin, M.D. | James S. Thompson, M.D., F.A.C.S. | Lacy E. Thornburg, M.D.
Jesse (Jay) L. West IV, M.D. | Matthew B. Massey, M.D. | Samuel S. Abrams, M.D. | Christie M. Lehman, M.D., PM&R

PLEASE PRINT LEGIBILY AND COMPLETE ALL INFORMATION

PATIENT INFORMATION:

Patient's Name:____ DOB: _________________SS#:_________________________

Mailing Address: ____ City/State:_____________________________ Zip:__________

Please indicate preferred contact phone number: □ Home Phone:__________________________ □ Cell:__________________________

Email address: ____

Employer:______________________________________ Phone:________________________City/State:_________________Zip:________

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INSURANCE INFORMATION:

PRIMARY INSURANCE CARRIER:__________________________________ Policy Holder's Name:______________________________

DOB:_____________________ Policy Holder's SS#:_______________________________ Policy ID#:_____________________________

Group#:___________________ Relationship to policyholder: □ Self □Spouse □ Child □Other

SECONDARY INSURANCE CARRIER:______________________________ Policy Holder's Name:______________________________

DOB:_____________________ Policy Holder's SS#:_______________________________ Policy ID#:_____________________________

Group#:___________________ Relationship to policyholder: □ Self □Spouse □ Child □Other

****

RESPONSIBLE PARTY/GUARANTOR INFORMATION:

Name:___________________________________Address:__________________________________ City/State:______________ Zip:_______

Home Phone:______________________________________ Cell:______________________________ Work:__________________________

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FOR PATIENTS THAT HAVE MEDICARE PART B, PLEASE COMPLETE BELOW

Do you currently reside in a Skilled Nursing Facility? □YES □NO Admission Date:_______ Discharge Date:______

If "YES" please provide name of facility and address: ____

Are you currently receiving any type of Home Health Services ? □YES □NO

****

Signature of Patient/Legal Guardian:_____________________________________ Date:_________________________