(Office Use Only) Acct#:_____Dr:_____

CAROLINA HAND and SPORTS MEDICINE, P.A.

Samuel S. Abrams, M.D. | Christopher T. Lechner, M.D. | Bruce I. Minkin, M.D.
Lacy E. Thornburg, M.D. | Jesse (Jay) L. West IV, M.D | Christie M. Lehman, M.D., PM&R

****PLEASE PRINT LEGIBILY AND COMPLETE ALL SECTIONS OF 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:_____

Primary Care Physician:_____ Referring Physician:_____

****

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

Relationship to patient: _____

Name:_____Address:_____ City/State:_____ Zip:_____

Home Phone:_____ Cell:_____ Work:_____

****

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:_____