

CAROLINA HAND and SPORTS MEDICINE, P.A.

Christopher T. Lechner, M.D. | Bruce I. Minkin, M.D. | Lacy E. Thornburg, M.D. |
Jesse (Jay) L. West IV, M.D | Travis Snyder, PA-C

****PLEASE PRINT LEGIBLY AND COMPLETE ALL SECTIONS OF INFORMATION****

PATIENT INFORMATION

Patient's Name: _____ DOB: _____ SS#: _____

If patient is a minor, provide responsible party: _____ Relationship to patient: _____

Mailing Address: _____ City/State: _____ Zip: _____

Please indicate preferred contact phone number: Home: _____ Cell: _____

Email address: _____ Decline to provide Do not have email

Employer: _____ Phone: _____ City/State: _____ Zip: _____

Primary Care Physician: _____ Referring Physician: _____

PREFERRED PHARMACY: _____ City/State: _____ Phone: _____

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 _____

PATIENTS THAT HAVE MEDICARE PART B AS YOUR PRIMARY INSURANCE, PLEASE COMPLETE

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