Dr._____
Appt Date:_____

PATIENT INFORMATION SHEET

Last Name	First Name	Middle Name	Nick Name

Address	City	State	Zip

Primary Phone	Secondary Phone	Email Address	☐ Phone ☐ Mail ☐ Online Portal Account

Social Security Number	Date of Birth	Age	Sex	Marital Status	Preferred Method of Contact

Employed By	Occupation	Years with Firm	Work Phone

Name of Spouse	Employed By	Spouse's Date of Birth	Work Phone

In Case of Emergency: Notify	Relationship to Patient	Phone

If Patient is under the age of 18:

Father's Name	Date of Birth	Employer	Work Phone

Mother's Name	Date of Birth	Employer	Work Phone

MEDICAL INSURANCE INFORMATION

1. PRIMARY INSURANCE
   Name of Carrier: _____ Policy Number:_____
   Subscriber's Name:_____ Subscriber's DOB:_____
   Insurance Phone: _____ Group Number:_____
   Is this an Exchange Policy: _____ Effective Date:_____
2. SECONDARY INSURANCE
   Name of Carrier: _____ Policy Number:_____
   Subscriber's Name: _____ Subscriber's DOB:_____
   Insurance Phone: _____ Group Number:_____
   Is this an Exchange Policy: _____ Effective Date:_____

Worker's Comp Insurance Company	Claim#	Case Manager/Adjuster	Contact Information

All professional services rendered are charged to the patient. If you have supplied us with insurance information, we will help you file a claim. The patient is responsible for all fees, regardless of insurance coverage and flexible spending accounts. Please remember that you carry the insurance and we cannot accept blame for lack of coverage or slow payment by the insurer. It is customary to pay any co-pay, deductible or percentage amount due at the time of service unless advance arrangements have been made. A payment must be made on any balances every 30 days thereafter to avoid a billing fee. If payment arrangements cannot be agreed upon, the amount due will be considered delinquent and may be subject to legal action or assignment to a collection agency. Collection fees and interest will accrue if account is turned for collection. Returned/NSF check fees apply.

Recognizing the inherent risk of transmission of contagious diseases, especially during surgery, I voluntarily agree to be tested for such diseases as hepatitis, syphilis, HIV/AIDS, herpes, etc., when deemed necessary by physician. Questions should be discussed with your physician. I hereby authorize Idaho Hand Center (IHC) to render treatment. I further authorize IHC to release any medical records to my insurance carrier to facilitate processing and authorize my insurance carrier to pay all benefits directly to IHC. I understand that IHC has a Privacy Notice regarding my confidential medical information. I further acknowledge that I may view the policy in the IHC waiting room, during normal business hours, or may request a copy at any time. As a way of confirming your identity and to protect against healthcare fraud, we will check picture ID at the time of your visit. With your permission we will scan your photo ID into our computers as a way to confirm your identity now and in the future. IHC, along with multiple other clinics and healthcare institutions participates with Idaho Health Data Exchange in sharing health information about you, as needed for your care. You must opt out of this program if you do not want to participate.

Patient or Responsible Party's Signature: (Patient must be 18 or older to sign) **Date**