SEACOAST HAND THERAPY

Patient Legal Name		**Male/Female/Non-Binary**	**Married?**
Mailing Address	**City**		**State / Zip**
Date of Birth	**Email Address**	**Social Security#** *(for billing purposes)*	
CIRCLE BEST # TO LEAVE MESSAGE	**[1] Home Phone#**	**[2]Work Phone#**	**[3] Cell Phone#**
Employer			
Name of Referring Physician		**Primary Care Physician**	
Reason For Visit	**Have you had therapy in the past year?**	**From_____to_____**	

Please provide your insurance cards for copy	**IF GAURANTOR IS **OTHER** THAN CARD STATES - please complete below
GUARANTOR NAME	*DATE OF BIRTH*
PATIENT'S RELATIONSHIP TO GUARANTOR	*[ ] SELF [ ] SPOUSE [ ] CHILD*

IS THIS A WORKER'S COMPENSATION CLAIM? or an AUTO INSURANCE CLAIM?

YES NO DATE OF INJURY	**YES NO DATE OF ACCIDENT**
WORKERS COMP INSURANCE COMPANY	**AUTO INSURANCE COMPANY NAME**
CLAIM # **ADJUSTER**	**PHONE #**

I authorize the release of any medical information necessary to process my disability and/or medical claim. I authorize payment of medical benefits to Seacoast Hand Therapy for services rendered. I understand that I am fully liable for any services not paid for on my behalf. I have read and completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested.

As of today _____ Are you receiving any "HOME HEALTH CARE/SERVICES" ? ____YES _____NO

_____ _____

Signature: Patient, Guardian, or Personal Representative ***Date***

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