SEATTLE HAND SURGERY GROUP
600 BROADWAY, SUITE 440
SEATTLE, WA 98122
(206) 292-6252

PATIENT REGISTRATION

Name: _____ ☐ Male ☐ Female Birth Date: _____
LAST FIRST MIDDLE INITIAL

Primary Phone: _____ ☐CL ☐WRK ☐HM Secondary Phone: _____ ☐CL ☐WRK ☐HM

Email: _____ Employer of Patient: _____

☐ **Please use address from my WA Driver License or State ID (provide to registrar)**

Address 1: _____
STREET (REQUIRED) CITY STATE ZIP CODE

Address 2: _____
MAILING (IF DIFFERENT FROM ABOVE) CITY STATE ZIP CODE

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White or Caucasian ☐ Other or Undetermined

Referring Provider _____ ☐ NIS
NAME GROUP PHONE ADDRESS AND/OR CITY

Primary Care Provider (PCP) _____ ☐ NIS
NAME GROUP PHONE ADDRESS AND/OR CITY

Pharmacy Name and Address: _____ _____
NAME ADDRESS

Is this visit for a job related injury or occupational disease? ☐ Yes ☐ No Date of Injury or Onset of Symptoms: _____

Have you opened a Labor & Industries claim? ☐ Yes ☐ No If yes, claim #: _____

Complete the following if your employer at the time of injury is privately insured.

Workers Compensation Company: _____

Address: _____ Claim #: _____

If privately insured, please fill in the following information and present your insurance cards upon completion of this form to the reception desk.

Primary Insurance _____

Subscriber Name: _____ Relationship: ☐ Self ☐ Other _____
RELATIONSHIP / DOB

Secondary Insurance _____

Subscriber Name: _____ Relationship: ☐ Self ☐ Other _____
RELATIONSHIP / DOB

Should an emergency occur while you are at Seattle Hand Surgery, who should we contact? (other than your residence)

Name: _____ Relationship: _____ Phone: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy by the Notice by calling 206-292-6252, requesting one at this office, or on the web at www.seattlehand.com.

_____ _____
SIGNATURE DATE

As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

_____ _____ _____
SIGNATURE RELATIONSHIP DATE

AUTHORIZATIONS

I AUTHORIZE THE SEATTLE HAND SURGERY GROUP, THE SEATTLE HAND REHABILITATION CLINIC, AND THE SEATTLE HAND SURGERY UNIT TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY OR MY DEPENDENT'S EXAMINATION OR TREATMENT ONLY TO THE AUTHORIZED INSURANCE CARRIER, LEGAL COUNSEL, OR REQUESTING PHYSICIAN. I AUTHORIZE THE CLINIC TO OBTAIN MEDICATION HISTORY ELECTRONICALLY FROM MY PHARMACY BENEFIT ADMINISTRATOR.

_____ _____
DATE SIGNED (Patient, or Parent or Guardian, if Minor)

ASSIGNMENT OF INSURANCE BENEFITS

I AUTHORIZE THE PAYMENT OF SURGICAL AND/OR MEDICAL BENEFITS TO BE MADE TO THE PHYSICIANS OF THE SEATTLE HAND SURGERY GROUP, THE SEATTLE HAND REHABILITATION CLINIC, AND THE SEATTLE HAND SURGERY UNIT FOR SERVICES RENDERED TO MYSELF OR MY DEPENDENTS COVERED UNDER MY INSURANCE. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ANY AND ALL MEDICAL BILLS INCURRED.

_____ _____
DATE SIGNED (Patient, or Parent or Guardian, if Minor)