

THE MILWAUKEE HAND CENTER - PATIENT REGISTRATION

Please Print

1. Patient Information

Name: Mr. Mrs. Ms.		Age:	Sex:	Birthdate:	<input type="checkbox"/> Married <input type="checkbox"/> Single
Address: <input type="checkbox"/> I live in an assisted living facility		SSN:	Email (to send appointment reminders)		
City:	State:	Zip:	Home Phone: () ()	Work Phone: () ()	Cell Phone: () ()
Occupation:		Employer:	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-time <input type="checkbox"/> Not working	Years Employed	
Employer Address:		Employer City:	State:	Zip:	

If the person responsible for the bill is other than above, fill out the top section on the reverse side of this form

2. Primary Insurance Carrier

___ Worker's Compensation [claim# _____] note: we will still need to make a copy of your regular insurance card ___ Humana ___ Anthem/Blue Cross ___ Aetna ___ UMR (only for CSM and Aurora employees o/w out-of-network) ___ Medicare note: we participate in Medicare but not many 'Medicare replacement/complete' plans (check with your plan coverage) ___ United Health Care note: we are out of network providers. Make sure you understand your policy benefits _____(initials) ___ Other _____ note: we participate in many other plans. Check with your carrier or policy for benefit levels.

3. Secondary Insurance Carrier (if none, write 'none' in the space)

--

We will make a copy of your secondary insurance card or claim. Our staff may still ask you to complete the back side information.

4. Referral information

Your primary doctor (i.e. internist, family practitioner, or general practice doctor)	
MD Last Name:	MD First Name:
Name of facility or person who referred you to us	<input type="checkbox"/> This person is my physician <input type="checkbox"/> I was referred by the Emergency Room <input type="checkbox"/> This person is a friend or family member <input type="checkbox"/> This person has been a patient in your office

5. Reason for your appointment

Describe what is wrong with your hand or arm and any prior tests or treatment for it	
.....	
When did your problem begin?	Involves which hand/arm most ___ LEFT ___ RIGHT
Is your problem a result of a work injury Yes ___ No ___	A motor vehicle accident Yes ___ No ___

I certify that the above information is correct. In order to provide the doctor with complete information regarding my problem, I give permission to obtain x-rays, lab test results, and medical records relating to my problem from other physicians, hospitals, and health care providers. In order to submit claims to your insurer, I authorize release of medical information to my carrier or in the case of Worker's Compensation, my employer. I request that benefits payable to me or on my behalf be made directly to The Milwaukee Hand Center (MHC) for any services furnished. I authorize Medicare to furnish the above named any information regarding my Medicare claim under Title XVIII of the Social Security act. I request that commercial insurance company benefits otherwise payable to me be assigned to the doctors on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier and that our office does not third party bill. I authorize the taking of photographs or video in the treatment of my case. A copy of this signature is valid as the original. I accept financial responsibility for rendered medical care and will promptly remit payment for services not fully paid by insurance. I understand that interest is assessed on past due balances and delinquent accounts are forwarded to an outside collection agency. Collection fees of thirty to fifty percent of the outstanding balance is added to the unpaid balance. Dr Watchmaker has an ownership interest in Orthopaedic Hospital of Wisconsin. In the course of your diagnosis and/or treatment at our office, you may be referred for services there. If you prefer that the services for which you are referred be provided at a different facility, please notify one of our staff members at, or as soon as possible after, the time of such referral so that alternative arrangements can be made. I understand that MHC also has contract ties to Aurora Healthcare through the Aurora Direct Network and Columbia St. Mary's through The Columbia St. Mary's Physician Network. I acknowledge that at registration, I received a copy of this office's privacy policy as required by federal HIPPA regulation. Unless otherwise notified by you, our office will share information about your condition with your immediate family such as spouse, parent, or adult children of elderly patients. Notify us if you do not wish immediate family to be able to attend your office visits or be privy to your medical care with us. If I provided my email address and phone number, I authorize MHC to use these as means to communicate with me about my appointments, treatments, and follow-up. I understand that x-rays can be harmful to developing fetuses and that I will notify the office staff prior to any x-ray being taken if there is any possibility of pregnancy.

Patient Signature _____ Date _____
 (if minor, have legal guardian/parent sign)

Please Print

6. Primary Insurance Card Holder Information (if other than Section 1)

Name: Mr. Mrs. Ms.	Age:	Sex:	Birthdate:
Address:	SSN:		
City:	State:	Zip:	Home Phone: Work Phone:
Occupation:	Employer:		
Employer Address:	Employer City:	State:	Zip:

7. Primary Insurance

8. Secondary Insurance

Primary Insurance Company:	Secondary Insurance Company
Address:	Address:
Insured: (Name on card):	Insured (Name on card):
Relationship to insured: Self Spouse Child Other _____	Relationship to insured: Self Spouse Child Other _____
Insured ID Number:	Insured ID Number
Group Number or Company Name:	Group Number or Company Name:
Effective Date:	Effective Date:
Birthdate of insured:	Birthdate of insured: