

Cedar Valley Hand Surgery, PLC

Account # _____

Last Name	First	M.I.	Social Security #	Date of Birth	Marital Status	Sex	
				S M W D SEP	M F		
Address			City/State/Zip				
Home Phone #		Work Phone #		Cell Phone #			
Patient's Employer		Employer Address		City/State/Zip			
Insured / Responsible Party's Name		Insured's Social Security #		Insured's Date of Birth		Home Phone #	
Insured's Address (If different from above)		City/State/Zip		Relationship to Patient		Work Phone #	
Insured's Employer Name		Employer's City/State/Zip		Insured's ID #			
Person to Contact in Case of an Emergency				Home Phone #		Relationship to Patient	
Area Dr Needs to Exam (Right / Left / Both / Finger(s), Hand, Elbow, Shoulder)				Family Physician		Referring Physician	
Were X-Rays taken for this Injury or Problem?		Where were X-Rays taken?		EMG Test		Accident Date	
Yes No							
Work Related Injury		Has this Injury been Reported to your Employer?		Auto Accident:		Liability Claim:	
Yes No		Yes No		Yes No		Yes No	
INSURANCE INFORMATION							
<i>A Photocopy of your Insurance Card is Maintained as a Part of your Permanent Medical Record.</i>							
<i>Please Notify the Receptionist of any Changes in your Insurance Coverage.</i>							
Signature on File Authorization							
<i>Assignment of Benefits/Authorization to Release Medical Information:</i>							
I hereby assign all medical benefits to which I am entitled to Cedar Valley Hand Surgery in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Cedar Valley Hand Surgery to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as original.							
Signature: _____				Date: _____			
I authorize transfer of medical information relevant to my care and progress from Cedar Valley Hand Surgery to any other of my treating physicians or therapists.							
Signature: _____				Date: _____			
<i>Medicare Signature Authorization: (Medicare Patients On/v)</i>							
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. <i>(Section 112B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)</i> Regulations pertaining to Medicare assignment of benefits also apply.							
Beneficiary's Signature				Date:			

Cedar Valley Hand Surgery Medical History Form

Do you have or have you at anytime in the past had:			
Illness	Current	Past	Never
Hepatitis (Yellow Jaundice)			
Heart Problem			
High Blood Pressure			
Asthma			
Ulcers			
Cancer			
TB (Tuberculosis)			
Arthritis			
Polio			
Diabetes			
Rheumatic Fever			
Seizure Disorder			
Headaches (Migraine)			
Is there a family history of: High Blood Pressure.		Diabetes T T Cancer T ₁ TB	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you currently taking any medications? Please List Below:	
Medication Name:		Dosa2e:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you allergic to any foods or medications? Please List Below:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you use alcohol?	(How much?)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you smoke?	(How much?)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you Latex Sensitive?	

Reviewed by :

Date: