Name:
DOB:
Chart:
Age:
Date:

(414) 453-7418 **HAND TO SHOULDER SPECIALISTS OF WISCONSIN** www.hsswi.com

- ☐ Mayfair Professional Building, 2500 N. Mayfair Road, Suite 670, Milwaukee WI 53226
- ☐ Glendale OHOW Medical Office Building, 525 W. River Woods Parkway, Suite 230, Glendale, WI 53212
- ☐ Elmbrook Office, 19475 W. North Avenue, Suite 302, Brookfield, WI 53045
- ☐ Cedarburg Office, W62 N208 Washington Ave • Cedarburg, WI 53012

PATIENT INFORMATION

Appointment Date _____ Referral Source _____

Appointment with Dr. _____ Primary Physician _____

If injury, date of accident/injury _____ Social Security# _____

Patient Name _____ Age _____ Date of Birth _____

Address _____ City/State/Zip _____

Race Choices: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Type-Unknown ☐ White
Ethnicity Choices: ☐ Hispanic Origin ☐ Non-Hispanic ☐ Type-Unknown

Language: _____

Employer _____ Home Phone _____

Employer Address _____ Work Phone _____

City/State/Zip _____ Cell Phone _____

Spouse (Parent) Name _____ Email _____

Spouse (Parent) Employer _____ Spouse (Parent) Date of Birth _____

PLEASE READ AND SIGN BELOW

I agree that Hand Surgery LTD may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

All professional services are rendered payable by the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is ultimately responsible for all charges incurred.

I hereby authorize Hand Surgery Ltd. to furnish to my insurance company(ies), or their representatives, information concerning my (my dependent's) illness and treatment. I hereby assign to Hand Surgery Ltd. all payments for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by my insurance (less contractual write offs).

I understand and agree that in the event that I default on any payments due and owing Hand Surgery Ltd., I will pay any and all costs of collection of such payment due and owing, including, without limitation, third party collection agency fees. This is agreed to as of the date below.

I acknowledge that Doctors Meister, Crimmins, Siverhus and Hodgson of this office have an ownership interest in Orthopaedic Hospital of Wisconsin, and Doctors Buebendorf and Crimmins have an ownership interest in the Wauwatosa Surgery Center. In the course of my diagnosis and/or treatment at this office, I may be referred for services at these facilities. If I prefer that the services for which I am referred be provided at a different facility, I have the right to notify the HSL staff at, or as soon as possible after, the time of such referral so that alternative arrangements can be made.

SIGNATURE OF PATIENT (PARENT OR GUARDIAN) ***DATE***

_____ _____

Name:
DOB:
Chart:
Age:
Date:

PATIENT NAME _____

DATE _____

Please present your insurance card(s) to the receptionist for copying purposes and fill in the information below.

PRIMARY INSURANCE COVERAGE

Name of Insurance _____

Claims Address _____

City/State/Zip _____

ID # _____

Group # _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber Social Security # _____

SECONDARY INSURANCE COVERAGE

Name of Insurance _____

Claims Address _____

City/State/Zip _____

ID # _____

Group # _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber Social Security # _____

Are you claiming your injury or medical condition under Worker's Compensation?

_____ Yes _____ No **If yes, please complete an additional form obtained from the receptionist.**