(Office Use Only) Acct#:_____Dr:_____

CAROLINA HAND and SPORTS MEDICINE, P.A.

Christopher T. Lechner, M.D. Adam M. Starr, M.D. Thomas A. Starnes, M.D. Spencer H. Moore, M.D.
Jesse (Jay) L. West IV, M.D Travis Snyder, PA-C T. Marc Barnett, M.D. Jessica Hancock, NP-C

****PLEASE PRINT LEGIBILY AND COMPLETE ALL SECTIONS OF INFORMATION****

*****PLEASE RETURN ALL FORMS BACK TO THE FRONT DESK UPON COMPLETION*****

PATIENT INFORMATION

Patient's Name: _____DOB: _____SS#:_____

If patient is a minor, provide responsible party:_____ Relationship to patient:_____

Mailing Address: _____City/State:_____ Zip:_____

Please indicate preferred contact phone number: □ Home:_____ □ Cell:_____

Email address: _____ □ Decline to provide □ Do not have email

Employer:_____ Phone:_____City/State:_____Zip:_____

Primary Care Physician:_____ Referring Physician:_____

PREFERRED PHARMACY: _____City/State:_____ Phone:_____

****

INSURANCE INFORMATION *PLEASE INITIAL _____

PRIMARY INSURANCE CARRIER:_____ Policy Holder's Name:_____

DOB:_____ Policy Holder's SS#:_____ Policy ID#:_____

Group#:_____ Relationship to policyholder: □ Self □Spouse □ Child □ Other_____

SECONDARY INSURANCE CARRIER:_____ Policy Holder's Name:_____

DOB:_____ Policy Holder's SS#:_____ Policy ID#:_____

Group#:_____ Relationship to policyholder: □ Self □Spouse □ Child □ Other_____

****

PATIENTS THAT HAVE MEDICARE PART B AS YOUR PRIMARY INSURANCE, PLEASE COMPLETE

Do you currently reside in a Skilled Nursing Facility? □YES □NO Admission Date: _____ Discharge Date: _____

If "YES" please provide name of facility and address: _____

Are you currently receiving any type of Home Health Services? □YES □ NO