

# Prairie



## Shoulder, Elbow & Hand Center

### **Patient Information**

Name: Mr. /Mrs. /Ms. \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip

Age: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F Marital Status: Single / Married / Divorced / Widowed

Social Security No.: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Name of Emergency Contact **not** living with you: \_\_\_\_\_

Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Who referred you? \_\_\_\_\_ Family Doctor: \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_ **Date of injury :** \_\_\_\_\_

### **Medical Insurance Information**

**IS THIS A WORK COMP CLAIM?** Yes / No Primary Insurance Company: \_\_\_\_\_

**AUTO ACCIDENT?** Yes / No

**LIABILITY CLAIM?** Yes / No I.D #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship to Policy Holder: \_\_\_\_\_

Policy Holder's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship to Policy Holder: \_\_\_\_\_

### **Responsible Party (if patient is under the age of 19)**

Name: Mr. /Mrs. /Ms. \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_