

Patient Information

Today's Date: _____ New Patient: Yes No Prior Patient New Problem: Yes No
Name: _____ Date of Birth: _____ Male Female
SSN: _____ Full Address: _____

Best Phone Number to Reach You: _____ Email: _____
Employer: _____ Occupation: _____ Years: _____
Employer Address & Phone: _____ Can We Call You at Work: Yes No

Complaint or Problem: _____

Which Side Involved: Right Left Which Area/Finger Involved: _____ Your Dominant Hand: Right Left
Injury Occurred Where: Work Home School Auto Accident Other: _____
Date of Injury: _____ Is This Problem in Any Way Work Related: Yes No Are You Sure: Yes No
How Did Injury Occur: _____

Which Health Care Provider Sent You to Us: _____
If Not Referred by Health Care Provider: Phone Book Internet Friend Family Member Attorney Other
Have Any of the Following Studies Been Completed/Date: X-Rays _____ MRI _____ CT Scan _____ Nerve Studies _____
Have Any of These Treatments Been Tried: Medication Physical Therapy Pain Blocks Acupuncture Surgery
Other Treatments Tried: _____
Do You Have an Attorney for This Injury: Yes No Attorney Name: _____
Preferred Pharmacy: _____ Location: _____ Phone: _____

If Patient is a Minor: Parent or Guardian Name, Address & Phone: _____

People with Whom We Can Discuss Your Treatment/Care Plan and/or Financial Account:
Name: _____ Phone Number: _____ Relationship: _____
Name: _____ Phone Number: _____ Relationship: _____
Name: _____ Phone Number: _____ Relationship: _____

Permission to Treat: "I give my permission for the physicians and staff of Lowcountry Hand Center, PC, to evaluate and treat my (or my child's/dependent minor's) upper extremity related problem in accordance with accepted general medical practices and within the community standard of care. I understand that different treatment options may be considered, and additional tests or examinations may be required. I understand that I am an important part of the treatment process, and that I should ask questions, do personal research on my condition, and do all I can to ensure the treatment plan is thoroughly discussed, understood, and carried out. I will also comply with the policies and procedures of Lowcountry Hand Center, PC, as provided to me."

Patient/Parent/Guardian Signature: _____ Date: _____

IF YOU NEED HELP READING, COMPLETING, OR UNDERSTANDING THIS FORM, PLEASE TELL THE RECEPTIONIST
We Reserve the Right to Change Our Policies and Procedures at Any Time