Patient Registration Form

Hand Surgery of Northern Michigan
(231) 935-0800 • Fax (231) 935-0808

Patient Last Name _____ First _____ Middle _____

Sex: ❒ Male ❒ Female Single ❒ Married ❒ Widowed ❒ Divorced ❒

Birthdate _____ Age _____ Social Security # _____

Mailing Address _____ City _____ State _____ Zip _____

Street Address (if you have PO Box) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

By providing your email address, you will be able to access our patient portal for appointment reminders, statement balances and prescription refill requests.

Preferred Pharmacy _____ City _____

Employer _____ Address _____

Referring Doctor _____

Primary Care Doctor _____

Responsible party (Parent escorting minor to visit) _____

Sex: ❒ Male ❒ Female Single ❒ Married ❒ Widowed ❒ Divorced ❒

Birthdate _____ Social Security # _____

Mailing Address _____

Mailing Street Address (if PO Box) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Insurance subscriber name _____ Birthdate _____

You are here due to: **(If any injury, please provide date of injury _____)**

❒ Other
❒ Workman's Comp
You must provide us with written authorization from you employer with insurance carrier information.

❒ Liability
❒ Auto Accident
Is your health insurance primary? Yes No

In Emergency:

Please contact _____ Relationship _____

Address _____ Phone _____

Signature _____ Date _____

Signature _____ Date _____