the HandClinic of Austin

Confidential Patient Information

Name _____ Date of birth _____

Address _____ Phone _____

City _____ State_____ Zip _____ Email _____

If minor, parent name _____

Emergency contact _____ Relationship _____

Emergency contact number _____

Primary Care Physician _____ Phone _____

Is this Worker Comp? Yes ☐ No ☐

For Workers Comp:

Employer _____ Social security number _____

Adjuster _____ Phone number _____

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of the medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ **Date**_____