Peter J Campbell, MD
Josh C Vella, MD
Hand Surgery Consultants

Patient Registration

Date: _____ ☐ New ☐ Update

Name: _____ Social Security #: ___ - ___ - ____ PID#: _____
Last First MI (Office Use Only)

Date of Birth: _____ Age: _____ ☐Male ☐Female ☐Single ☐Married ☐Other

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

EMERGENCY CONTACT: Name: _____ Relationship: _____ Phone: ( ) _____

RESPONSIBLE PARTY: _____ Social Security #: ___ - ___ - ____
Last First MI

Date of Birth: _____ ☐Male ☐Female Relationship to patient: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Employer: _____ Occupation: _____

REFERRAL INFORMATION: Physician (or other): _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

PRIMARY CARE PHYSICIAN: Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE: _____ Address: _____

ID#: _____ Group: _____ Primary Care Physician: _____

Policy Holder Name: _____ Date of Birth: _____ Relationship: _____

SECONDARY INSURANCE: _____ Address: _____

ID#: _____ Group: _____

Policy Holder Name: _____ Date of Birth: _____ Relationship: _____

3200 East Camelback Road, Suite 180 - Phoenix, Az - 85018
Ph (602) 393-HAND - fax (602) 393-2329 - hscaz@hotmail.com

*****Note: If problem or injury was the result of an accident, please fill out the applicable portion below.**

On the job injury/accident (please call your employer for this information):

INDUSTRIAL INSURANCE: _____ Address: _____

Claim #: _____ Date of Injury: _____ Case Manager's Name: _____

Employer's Name: _____

Other injury/accident:

AUTOMOBILE (OR OTHER) INSURANCE: _____ Address: _____

Claim #: _____ Date of Accident: _____ Attorney's Name: _____

If applicable, where were x-rays taken? (Hospital, etc..) _____

All patients – please read and sign below

I hereby authorize Hand Surgery Consultants/Peter J Campbell, MD to release to my insurance company, or its representatives, any information including the diagnosis, history, treatment, prognosis and charges of such medical care. I also authorize and request my insurance company to PAY DIRECTLY to the above named physician the amount due me in my pending claim for medical treatment or services rendered. This assignment and release will remain in effect until revoked by me, in writing.

Patient or Responsible Party Signature: _____ Date: _____

I have received a copy of the privacy policy.

Patient or Responsible Party Signature: _____ Date: _____