CJHS - WORKER'S COMPENSATION AND MOTOR VEHICLE ACCIDENT - PLEASE PRINT LEGIBLY

Last Name: _____ First Name: _____ MI: _____ Age: _____

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

Birthdate: _____ SS#: _____ Email Address: _____

Sex: ◯ Male ◯ Female Marital Status: _____ Home Phone #: _____ Cell Phone #: _____

Employer: _____ Work Phone: _____ Occupation: _____

Employer Address: _____

Referring MD: _____ Phone: _____

Referring MD Address: _____

Family Physician: _____ Phone: _____

Family Physician Address: _____

Employment/ Student Status: ◯ Full time ◯ Part time ◯ Not Employed ◯ Self Employed ◯ Retired ◯ Military Duty

Guardian/ Spouse's Name: Relationship: Phone #:

Additional Information:

Race: ◯ Asian ◯ Black/African American ◯ American Indian ◯ White ◯ More than 1 race ◯ Unreported/ Refused to report

Ethnicity: ◯ Hispanic/ Latino ◯ Not Hispanic/ Latino ◯ Unreported/ Refused to report Language: _____

How did you hear about CJHS: Referred by name/ source:

◯ Worker's Compensation ◯ Motor Vehicle

Insurance Company: _____ Claim #: _____

Insurance Address: _____

Adjustor's Name: Adjustor's Phone Number:

Primary Health Insurance:

Insurance Company: _____ Specialist Copay: _____ Effective Date: _____

Insured's Name: _____ Address (If Different): _____

Relationship to insured: _____ Insured's Birthdate: _____ Insured's SS#: _____

ID#: Group #:

Injury/Accident Information:

Date of Injury/Accident: _____

Where did the Injury/Accident occur? _____

How did the Injury/Accident occur? _____

_____

Description of problem(s)/ symptom(s)? _____

_____

Previous Treatment: _____

I hereby authorize payment from the insurance company to be sent directly to Central Jersey Hand Surgery for any service rendered to me by the group.
I also authorize the release of medical information to my insurance company in order for Central Jersey Hand Surgery to complete necessary insurance forms.
You are personally responsible for the payment of all bills, if your claim is denied (for any reason).
You are also responsible for any co -insurance amounts, non-covered charges and any balance remaining after insurance payment to our office.
I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees will be given to me concerning the results of any treatment or operation. Doctors Pess, Decker, Gabuzda, Atik and Fedorcik will attempt to improve the patient over their present status, but cannot return the patient to normal status.

Patient's Signature: _____ Date: _____