CAYMAN HAND CENTRE
REGISTRATION FORM
(Please Print)

Today's date: DD/MM/YY	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
			Single / Married / Divorced / Separated / Widowed / Minor		

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Email Address:	Home phone no.:
P.O. box:	District: / ZIP Code: KY -	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Chose clinic because / Referred to clinic by (please check one box): Dr. ____________

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑Website ❑ Other ____________________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date : / / DD/MM/YY	Address (if different):	Home/Cell phone no.:
Occupation:	Employer:	Employer address:	Employer phone no.:

Is this patient covered by insurance?	❑ Yes	❑ No
Primary insurance Company:	ID#	

Subscriber's name:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:				

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Cayman Hand Centre to release any information required to process my claims. I agree to my clinical investigations being used for teaching purposes, no identifying information will be used.
I consent to attending Cayman Hand Centre as a patient, I further consent to & authorize my Attending Physician to perform such examinations, Investigations, care & treatment as deemed necessary. I understand that I may, at any time, refuse to undergo any particular procedure or accept any recommendations for treatment.

Patient/Guardian signature *Date*