The Carolina Hand Center

PATIENT INFORMATION

Date:_____

First Name_____MI_____Last Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Business Phone _____ Cell Phone _____

Birthdate _____ Email Address _____

Sex ____ Marital Status _____ Age ____ Social Security # _____ - _____ - _____

Race _____ Language _____ Ethnicity ❒ Hispanic / Latino ❒ Non Hispanic / Latino

Employment ❒ Full-time ❒ Part-time ❒ Retired ❒ Student ❒ Self-Employed ❒ Other_____

Referring M.D. _____ Family M.D. _____

Nearest relative / friend (not living in household) _____

Nearest relative / friend's telephone number _____

Which is your dominant hand? ❒ Right ❒ Left Which hand/arm is injured? ❒ Right ❒ Left

Date of accident or work injury _____ Time of Accident _____AM / PM

What type injury do you have? (i.e. cut, fracture, etc.) _____

_____

Where did injury occur? (i.e. home, work, friend's home, etc.) _____

How did injury occur? (i.e. fall, working in yard, etc.) _____

_____

EMPLOYER INFORMATION

Name _____Telephone_____

Address _____

City _____ State _____ Zip Code_____

IF PATIENT IS A MINOR

Parent responsible _____

Address (if different from patient) _____

City _____ State _____Zip Code _____

Home Phone _____ Business Phone _____

Employer_____ Social Security # _____ - _____ - _____ Birth Date _____