Badia Hand to Shoulder Center

3650 NW 82nd Avenue, Suite 103
Doral, FL 33166
Phone: (305) 227-4263 Fax: (305) 537-7222

Please Print **Advance Directive?** ___yes ___no

First Name: ______________________ **M.I.:**_______ **Last Name:** ______________________

Address: ____
Street **City** **State** **Zip Code**

Home Phone: ________________ **Work Phone:** ________________ **Cell Phone:** ________________

Date of Birth: ________________ **Social Security:** ________________ **Sex:** _____**Male** _____ **Female**

Email Address: ____

Marital Status: ___Single ___Married ___Divorced ___Widowed

Employment Status: ___Employed ___Unemployed ___Retired

Employer: ________________________ Occupation: ________________________

Employer Address: ____

Type of injury you are being treated for: ____work related ____auto accident ____sports injury ____other: ________________

Workers Comp or Auto Insurance Company Name: ________________________________

Address for Claims: ____
Street **City** **State** **Zip Code**

Adjuster Name: ________________________Phone/ Fax Number: ________________________

Primary Insurance Company Name: ________________________Phone: ________________

Policy Number: ________________________ Group Number: ________________________

Policy Holder Name: ________________________ Date of Birth: ________________________

Social Security Number: ________________________ Relationship to patient: ________________

Secondary Insurance Company Name: ________________________Phone: ________________

Policy Number: ________________________ Group Number: ________________________

Policy Holder Name: ________________________ Date of Birth: ________________________

Social Security Number: ________________________ Relationship to patient: ________________

Referring Physician: ________________________ Phone: ________________________

Emergency Contact (not in the same household): ________________ Relationship________________

Phone: ________________ Address: ________________________________

I do hereby consent to any medical care which is deemed advisable or necessary by my physician and grant authority to Badia Hand to Shoulder Center, to administer and perform all examinations, treatments, diagnostic procedures and surgeries needed now or in the future. I guarantee payment for all services rendered. All medical benefits including major medical benefits, private insurance and any other health plan, are assigned to Badia Hand to Shoulder Center. The signature below confirms all of the information provided herein is true and accurate. Photocopy of this consent is to be considered as valid as the original.

Signature: ________________________________ **Date:** ________________________