David J. Slutsky M.D.

THE SLUTSKY HAND & WRIST INSTITUTE

Diplomate, American Board of Orthopedic Surgery
Certificate of Added Qualifications in Hand Surgery (C.A.Q.H.S.)
Fellow, American Academy of Orthopedic Surgeons
Member, American Society for Surgery of the Hand
Founding Editor-in-Chief, The Journal of Wrist Surgery

PATIENT'S DEMOGRAPHIC INFORMATION

Patient First Name _____ M. Initial _____ Last Name _____

Date of Birth ___/___/___ Age____ Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Home Address_____CITY_____ZIP_____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone _____ Ext ____

E-mail address _____ Are you ◯ Right Handed or ◯ Left Handed

Where may we leave messages regarding your medical care? Circle all that apply: Home Cell Work

Who referred you to Dr. Slutsky? Physician Name _____ Friend _____

Internet Site_____ Insurance Site_____ Worker Comp Insurance _____ Other _____

EMPLOYMENT INFORMATION

(If patient is under 18 years old please include employment information for both parents.)

Your Name _____	Spouse Name _____
Employer _____	Employer _____
Address _____	Address _____
City _____	City _____
Work Phone ( ) _____ Ext _____	Work Phone ( ) _____ Ext ____
Social Security # _____-_____-_____	Social Security # _____-_____-_____
Occupation _____	Occupation _____
Emergency Contact Name _____	Address _____
not living with you Phone ( ) _____	Relationship _____

INJURY

Injury to ☐ Right Hand or ☐ Left Hand Provide Brief Description of injury or reason to be seen by the physician

_____

_____

Insurance: _____ ID # _____ Group # _____

Phone# _____ Date of Injury or onset of symptoms _____/_____/_____

☐ X-Rays ☐ MRI ☐ Physician/ER Report ☐ Consult ☐ Second Opinion

FINANCIAL RESPONSIBILITY AGREEMENT

How will you pay for your medical care and treatment? ☐ Insurance ☐ Check ☐ Cash ☐ Work Injury

Insurance Company _____ Insured's Name _____

Insurance card is required and will be photocopied by office staff. **Co-payment/deductable is due at time of service.**

I hereby authorize David J. Slutsky, MD to release any and all medical information to the above names insurance carrier for purposes of claims administration and evaluation utilization review and audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of the authorization. I have read this authorization and I understand it. I hereby assign David J. Slutsky, MD all money to which I am entitled for medical and/or surgical expenses relative to the services rendered by him, but not to exceed my indebtedness to said company. I understand that it is my sole responsibility to submit claims for reimbursement to my insurance company. Any amount paid over and above my indebtedness will be refunded to me when the bill is paid in full. I understand that I am financially responsible to David J. Slutsky, MD for charges not covered by this assignment. I further agree in the event of non-payment, I bear the cost of collection and/or court costs and reasonable legal fees should this be required. I understand that photographs, videos, videos and digital images may be recorded for educational purposes and I grant consent to this use. Under California law, Dr. Slutsky is required to inform you that he has a financial interest in Beach District Surgery Center, LLC to which he may refer you for services. There may be other organizations from which you can obtain these services. Dr. Slutsky will discuss alternatives with you if you wish.

Patient's Signature _____ Date _____/_____/_____

Parent's Signature for minor child _____