THE HAND CENTER
COLORADO

The Hand Center, P.C

Office of Kelley Wear, M.D.

www.HandCenterColorado.com

BROOMFIELD-THORNTON LOCATIONS

Phone: (303) 957-7116
Fax: (720) 536-5725

Today's Date ____/____/_____

Patient's Full Legal Name _____

Patient's Birth Date ____/____/_____ **Gender** _____ **SSN** ____-____-_____

Race _____ **Ethnicity** _____ **Marital Status** _____ **Email** _____

Phone Number 1. (____)____-_____ type _____ 2. (____)____-_____ type _____

Address **Street** _____

City _____ **State** _____ **Zip Code** _____

Primary Care Physician _____ **Phone** (____)____-_____

Referred By _____

Employer Information:

Employer's Name _____ **Phone** (____)____-_____

Employer's Address _____

_____

Emergency Contact:

Name _____ **Phone** (____)____-_____ type _____

Information of Person Who Carries Insurance, if different than patient:

Name _____ **Relationship to Patient** _____

Date of Birth ____/____/_____ **SSN**____-_____-_____ **Phone** (____)____-_____ type _____

Address _____

_____

Reason for your visit today

_____

Is this visit related to an Auto Accident or Work-Related Injury or Illness? _____

If yes: Date of Injury ____/____/_____ **Insurance Name** _____ **Claim #**_____

Adjuster _____ **Phone** (____)____-_____ **Fax** (____)____-_____

Pharmacy Information:

Name _____ **Phone** (____)____-_____

Address _____

City _____ **State** _____ **Zip Code**_____

Cross Streets _____

Is the patient RIGHT or LEFT handed? _____