Charlottesville Hand Surgery, PLC
Michael J. Devine, M.D.

PATIENT INFORMATION SHEET **Chart Number: _____**
(Please fill out completely)

Today's Date: _____ Sex ☐ M ☐ F Marital Status: _____ Age: _____ Birthdate: _____

Patient Name: _____ Soc Sec# _____
Last name First name Middle Initial

Physical Address_____
Street Address City State Zip

Mailing address if different from physical address _____
City State Zip

Home Phone #: _____ Cell Phone#:_____ Work Phone #:_____

Occupation: _____ Employer: _____Address: _____
Street City St Zip

Pharmacy where prescriptions should be called**:** _____

Referring Doctor:_____Primary Care Physician:_____

Emergency Contact:_____ Relationship:_____Phone #: _____

Insurance Policy Holder (if not the patient)

Name: _____DOB:_____Soc Sec #_____

Physical Address:_____P.O.Box_____
Street Address City State Zip

Home Phone:_____Work Phone:_____Cell Phone:_____

Responsible Party Information (if under 18 person accompanying patient)

Responsible Party Name: _____ DOB: _____ Soc Sec #: _____

Home Phone #: _____ Physical Address: _____

Employer: _____ Address: _____ Phone #: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS formerly HCFA) or its intermediaries or carriers or any other carriers, third party or such, any information needed for this or a related Medicare and/or other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or Charlottesville Hand Surgery who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply. This applies further to any contracts and/or agreements with any other insurance entities.
Signed: _____(SEAL) Date: _____