

Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

(414) 453-7418 **HAND TO SHOULDER SPECIALISTS OF WISCONSIN** www.hsswi.com

- ☐ The Offices at Mayfair, 2500 N. Mayfair Road, Suite 670, Milwaukee WI 53226
☐ Glendale OHOW Medical Office Building, 525 W. River Woods Parkway, Suite 230, Glendale, WI 53212
☐ Cedarburg Office, W62 N208 Washington Ave • Cedarburg, WI 53012
☐ Airport Office, 5007 S. Howell Ave., Suite 320 • Milwaukee WI 53207

PATIENT INFORMATION

Appointment Date _____ Referral Source _____

Appointment with Dr. _____ Primary Physician _____

If injury, date of accident/injury _____ Social Security# _____

Patient Name _____ Age _____ Date of Birth _____

Address _____ City/State/Zip _____

Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other
Race Choices: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Type-Unknown ☐ White
Ethnicity Choices: ☐ Hispanic Origin ☐ Non-Hispanic ☐ Type-Unknown

Language: _____

Employer _____ Home Phone _____

Employer Address _____ Work Phone _____

City/State/Zip _____ Cell Phone _____

Spouse (Parent) Name _____ Email _____

Spouse (Parent) Employer _____ Spouse (Parent) Date of Birth _____

PLEASE READ AND SIGN BELOW

I agree that Hand to Shoulder Specialists of Wisconsin may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

All professional services are rendered payable by the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is ultimately responsible for all charges incurred.

I hereby authorize Hand to Shoulder Specialists of Wisconsin to furnish to my insurance company(ies), or their representatives, information concerning my (my dependent's) illness and treatment. I hereby assign to Hand to Shoulder Specialists of Wisconsin all payments for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by my insurance (less contractual write offs).

I understand and agree that in the event that I default on any payments due and owing Hand to Shoulder Specialists of Wisconsin, I will pay any and all costs of collection of such payment due and owing, including, without limitation, third party collection agency fees. This is agreed to as of the date below.

I acknowledge that Doctors Meister, Crimmins, Hodgson, Wu, and Trenga of this office have an ownership interest in Orthopaedic Hospital of Wisconsin, and Doctor Crimmins has an ownership interest in the Wauwatosa Surgery Center. In the course of my diagnosis and/or treatment at this office, I may be referred for services at these facilities. If I prefer that the services for which I am referred be provided at a different facility, I have the right to notify the HSSWI staff at, or as soon as possible after, the time of such referral so that alternative arrangements can be made.

SIGNATURE OF PATIENT (PARENT OR GUARDIAN)

DATE

10/13/2026

Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

PATIENT NAME _____

DATE 10/13/2026 _____

Please present your insurance card(s) to the receptionist for copying purposes and fill in the information below.

PRIMARY INSURANCE COVERAGE

Name of Insurance _____

Claims Address _____

City/State/Zip _____

ID # _____

Group # _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber Social Security # _____

SECONDARY INSURANCE COVERAGE

Name of Insurance _____

Claims Address _____

City/State/Zip _____

ID # _____

Group # _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber Social Security # _____

Are you claiming your injury or medical condition under Worker's Compensation?

_____ Yes

_____ No

If yes, please complete an additional form obtained from the receptionist.