

PID#

GENERAL PATIENT INFORMATION

(This information is necessary for our files and will be considered confidential)

(Please check preferred contact number)

Date: _____

1 (_____) Home Work Cell

PATIENT LAST NAME _____ FIRST NAME _____ MIDDLE _____

2 (_____) Home Work Cell

ADDRESS _____ APT/LOT # _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____ AGE _____ SEX: Male Female PRIMARY CARE PHYSICIAN _____

Marital Status: Single Married Widowed Separated Divorced

Preferred Language: English Spanish Other: _____

REFERRED BY _____

Race: White/Caucasian Hispanic African American Asian Native American

EMPLOYED BY _____

(_____) WORK PHONE _____

OCCUPATION _____

E-MAIL _____

SPOUSE OR SIGNIFICANT OTHER INFORMATION

NAME _____ DATE OF BIRTH _____ PHONE # (_____) _____

IN CASE OF EMERGENCY

NAME OF PERSON IN CASE OF EMERGENCY OTHER THAN SPOUSE _____ RELATIONSHIP _____ EMERGENCY PHONE (_____) _____

IF THE PATIENT IS A MINOR OR STUDENT

RESPONSIBLE PARTY _____ RELATIONSHIP _____ D.O.B. _____ HOME PHONE (_____) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ SOCIAL SECURITY NUMBER _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME _____ POLICY HOLDER'S NAME _____ POLICY HOLDER'S DOB _____ PHONE (_____) _____

POLICY# _____ GROUP# _____ SOCIAL SECURITY NUMBER: _____

PATIENT RELATION TO POLICY HOLDER: SELF SPOUSE CHILD OTHER: _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME _____ POLICY HOLDER'S NAME _____ POLICY HOLDER'S DOB _____ PHONE (_____) _____

POLICY# _____ GROUP# _____ SOCIAL SECURITY NUMBER: _____

PATIENT RELATION TO POLICY HOLDER: SELF SPOUSE CHILD OTHER: _____

IS YOUR CONDITION RELATED TO AN ACCIDENT OF ANY KIND? NO YES WORK RELATED AUTO ACCIDENT

OTHER (EXPLAIN) _____ DATE OF INJURY: _____

DO YOU HAVE LEGAL ACTION PENDING REGARDING THIS INJURY? NO YES ATTORNEY NAME & PHONE: _____

IT IS YOUR RESPONSIBILITY TO PROVIDE YOUR INSURANCE COMPANY WITH ANY REQUESTED INFORMATION NEEDED TO PROCESS YOUR CLAIM. IF YOUR INSURANCE PLAN REQUIRES AUTHORIZATION FROM YOUR PRIMARY CARE PHYSICIAN IT IS **YOUR RESPONSIBILITY** TO HAVE THE AUTHORIZATION AT THE TIME OF YOUR VISIT. WITHOUT THE REQUIRED INFORMATION OR APPROPRIATE AUTHORIZATION, TODAY'S CHARGES MAY BE YOUR RESPONSIBILITY.

I AUTHORIZE THE DOCTOR TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER MEDICAL CARE. I AUTHORIZE AND REQUEST ARIZONA ORTHOPAEDIC ASSOCIATES AT GATEWAY, A DIVISION OF OSNA PLLC, TO RELEASE MY MEDICAL RECORDS TO ANY OTHER PHYSICIAN/MEDICAL FACILITIES DIRECTLY INVOLVED IN MY CARE, AND FOR THE PURPOSE OF ADMINISTERING CLAIMS. I HAVE BEEN MADE AWARE OF AOA'S NOTICE OF PRIVACY PRACTICES AND FINANCIAL POLICY. I HEREBY AUTHORIZE THE ASSIGNMENT OF PAYMENT OF MY MEDICAL BENEFITS TO AOA AT GATEWAY, A DIVISION OF OSNA PLLC. I UNDERSTAND I MAY RECEIVE SERVICES OR SUPPLIES THAT ARE NOT COVERED BY MY INSURANCE PLAN AND I AGREE TO BE DIRECTLY RESPONSIBLE FOR THESE EXPENSES. I UNDERSTAND COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. DELINQUENT ACCOUNTS MAY BE REFERRED TO A COLLECTION AGENCY FOR PAYMENT. ASSOCIATED COLLECTION AGENCY COSTS WILL BE YOUR RESPONSIBILITY.

PATIENT/ PARENT/ GUARDIAN SIGNATURE: _____ DATE: _____