❑ Francis K. Tindall, M.D.
❑ Brad R. Bruns, M.D.
❑ Richard C. Martin, M.D.
❑ David A. Camarata, M.D.
❑ Brian L. Shafer, M.D.
❑ Philip To, M.D.

OrthoArizona

ARIZONA BONE & JOINT SPECIALISTS

PATIENT REGISTRATION

❑ 5620 E. Bell Rd., Scottsdale, AZ 85254, P (602) 493-9361, F (602) 493-9508
❑ 13640 N. 7th Street, Phoenix, AZ 85022, P (602) 863-2040, F (602) 863-1140

❑ Laurie A. Scott, NP-C
❑ Christopher E. Lang, P.A.-C.
❑ Ryan Marinone, P.A.-C.

Last Name_____ First Name_____ MI ____ ☐ Male ☐ Female

Date of Birth ____/____/____ Age _____ Home Phone _____ Cell/Message Phone _____

Race_____ Ethnicity_____ Preferred Language_____

Mailing Address_____ APT# _____ City_____ State/Zip_____

Social Security #_____-_____-_____ Marital Status _____ Email _____

Employer/School_____ Employer/School City_____ State/Zip_____

Employer/School Phone #_____ Family Physician _____

Date Of Injury/Onset ____/____/____ Referring Physician _____

What Are You Being Seen For? _____ ☐ Left ☐ Right

☐ Industrial ☐ Auto Accident Cause of the Injury: _____

RESPONSIBLE PARTY INFORMATION

Note: Responsible Party is the Policy Holder

Full Name_____

Relationship to Patient _____

Address_____ APT _____

City_____ State _____ Zip _____

Phone Number _____

DOB____/____/____ SSN_____-_____-_____

Employer _____

EMERGENCY CONTACT INFORMATION

Full Name _____

Relationship to patient _____

City_____ State_____ Zip _____

Phone #_____Alt Phone #_____

Nearest Relative (not living w/you) _____

City_____ State_____ Zip _____

Phone #_____Alt Phone #_____

PRIMARY INSURANCE: *(circle insurance type below)*

Insurance Medicare Medicaid Self Pay Worker's Comp

Name of Insurance Co._____

Ins. Billing Address_____

Ins. City/State/Zip _____

Ins. Phone # _____ Fax #_____

Subscriber Name _____

Sub. DOB____/____/____Sub. SSN_____-_____-_____

Group # _____ Policy # _____

Effective Date of Coverage: ____/____/____

SECONDARY INSURANCE: *(circle insurance type below)*

Insurance Medicare Medicaid Self Pay Worker's Comp

Name of Insurance Co._____

Ins. Billing Address_____

Ins. City/State/Zip _____

Ins. Phone # _____ Fax #_____

Subscriber Name _____

Sub. DOB____/____/____ Sub. SSN_____-_____-_____

Group # _____ Policy # _____

Effective Date of Coverage: ____/____/____

I certify that the above information provided is true and correct and that I consent to treatment for the above injury or illness.

Patient/Parent-Guardian Signature:_____ **Date:** _____

If Parent-Guardian's signature appears above, please describe the relationship to the patient: _____