OrthoArizona

PID#

General Patient Information

FIRST NAME | MIDDLE | LAST | PREFERRED (OPTIONAL) | SOCIAL SECURITY #

SEX: ☐ MALE ☐ FEMALE DATE OF BIRTH: MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

ADDRESS | APT/SUITE# | CITY | STATE | ZIP CODE

CONTACT NUMBER: ☐ HOME ☐ WORK ☐ MOBILE ALTERNATE: ☐ HOME ☐ WORK ☐ MOBILE EMAIL:

REFERRING PHYSICIAN | PRIMARY CARE PHYSICIAN | PREFERRED METHOD OF CONTACT: ☐ Home ☐ Work ☐ Mobile ☐ Email ☐ Secure Messaging

RACE/ETHNICITY: ☐ WHITE/CAUCASIAN ☐ HISPANIC ☐ AFRICAN AMERICAN ☐ ASIAN ☐ NATIVE AMERICAN ☐ OTHER:

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER:

EMPLOYER: OCCUPATION: DATE OF INJURY:

EMERGENCY CONTACT

NAME | RELATIONSHIP | PHONE#

IF THE PATIENT IS A MINOR OR STUDENT

RESPONSIBLE PARTY | RELATIONSHIP | DATE OF BIRTH | PHONE# | SOCIAL SECURITY #

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY NAME

POLICY HOLDER'S NAME

POLICY HOLDER DATE OF BIRTH

POLICY/ID#

GROUP/ACCOUNT #

RELATIONSHIP TO POLICY HOLDER

SECONDARY INSURANCE

INSURANCE COMPANY NAME

POLICY HOLDER'S NAME

POLICY HOLDER DATE OF BIRTH

POLICY/ID#

GROUP/ACCOUNT#

RELATIONSHIP TO POLICY HOLDER

PREFERRED PHARMACY INFORMATION (OPTIONAL)

PHARMACY NAME | PHARMACY PHONE# | ADDRESS OR APPROXIMATE CROSSROADS

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

DO YOU HAVE LEGAL ACTION PENDING FOR 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 PRE-AUTHORIZATION FROM 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 PROCEDURE AND TREATMENT AS MAY BE NECESSARY FOR PROPER MEDICAL CARE. I AUTHORIZE AND REQUEST ORTHOARIZONA, AND ITS DIVISIONS, 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 ORTHOARIZONA'S NOTICE OF PRIVACY PRACTICES AND FINANCIAL POLICY. I HEREBY AUTHORIZE THE ASSIGNMENT OF PAYMENT OF MY MEDICAL BENEFITS TO ORTHOARIZONA AND ITS DIVISIONS. 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. DELIQUENT ACCOUNTS THAT HAVE BEEN DETERMINED TO BE "PATIENT RESPONSIBLE" BY THE INSURANCE CARRIER MAY BE REFERRED TO A COLLECTION AGENCY FOR PAYMENT. ASSOCIATED COLLECTION AGENCY COSTS MAY ALSO BE YOUR RESPONSIBILITY.

I HEREBY AUTHORIZE ORTHOARIZONA AND ITS DIVISIONS TO OBTAIN MEDICATION HISTORY FROM COMMUNITY PHARMACIES AND/OR PHARMACY BENEFIT MANAGERS FOR THE PURPOSE OF TREATMENT.

PATIENT/PARENT/GUARDIAN SIGNATURE: DATE: