OrthoArizona

PID#

General Patient Information

FIRST NAME | **MIDDLE** | **LAST** | **PREFERRED (OPTIONAL)** | **DATE OF BIRTH**

SEX: ☐ MALE ☐ FEMALE **SS #:** **MARITAL STATUS:** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED

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

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

REFERRING PHYSICIAN | **PRIMIARY CARE PHYSICIAN**

PREFERRED METHOD OF CONTACT ☐ Home ☐ Work ☐ Mobile ☐ Email ☐ Secure Messaging

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

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER:

EMERGENCY CONTACT

NAME | **RELATIONSHIP** | **PHONE#**

IF THE PATIENT IS A MINOR OR STUDENT

RESPONSIBLE PARTY | **RELATIONSHIP** | **DATE OF BIRTH** | **PHONE#**

ADDRESS | **CITY** | **STATE** | **ZIP CODE** | **SOCIAL SECURITY #**

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY NAME

POLICY HOLDER'S NAME

POLICY HOLDER DATE OF BIRTH

POLICY/ID#

GROUP/ACCOUNT #

RELATION TO POLICY HOLDER

SECONDARY INSURANCE

INSURANCE COMPANY NAME

POLICY HOLDER'S NAME

POLICY HOLDER DATE OF BIRTH

POLICY/ID#

GROUP/ACCOUNT#

RELATION TO POLICY HOLDER

PREFERRED PHARMACY INFORMATION (OPTIONAL)

PHARMACY NAME | PHARMACY PHONE# | ADDRESS OR APPROXIMATE CROSSROADS

IS YOUR CONDITION RELATED TO AN ACCIDENT OR 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 ADMINSTERING CLAIMS. I HAVE BEEN MADE AWARE OF ORTHOARIZONA'S NOTICE OF PRIVACY PRACTICES AND FINANCIAL POLICY. I HEREBY AUTHORIZE THE ASSIGMENT 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 DEDUCTABLES 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:**