ARIZONA ORTHOPAEDIC ASSOCIATES
AT GATEWAY

A DIVISION OF
OSNA

WELCOME TO OUR OFFICE

Arizona Orthopaedic Associates at Gateway
690 N. Cofco Center Court Ste. 290
Phoenix, AZ 85008 (602) 631-3161

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

2 ( ) ____________ ☐ Home ☐ Work ☐ Cell

PATIENT LAST NAME ____ FIRST NAME ____ MIDDLE ____

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 ADMINSTERING CLAIMS. I HAVE BEEN MADE AWARE OF AOA'S NOTICE OF PRIVACY PRACTICES AND FINANCIAL POLICY. I HEREBY AUTHORIZE THE ASSIGMENT 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:** ____________