Patient Name:	Last	First	Middle

Patient Address:	Street	Apt #	City/State	Zip

Patient: Phone	Home ( ) -	Work ( ) -	Other: ❒ Cell ❒ Pager ( ) -

May we contact you via email?
❒ No ❒ Yes - Email Address:

Date of Birth: Age SS# ❒ Male ❒ Female

❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Employed ❒ Student ❒ Homemaker ❒ Disabled

Patient Employer: **Patient Occupation:**

PARENT Name: Last First Middle SSN

PARENT Employer: ***Parent*** **Work Phone** ( ) -

Emergency Contact not living with you: Name **Home Phone** ( ) - **Work Phone** ( ) -

Who referred you to this office? **Who is your primary care physician?**

Is your medical condition related to an accident of *any* kind? ❒ **No** ❒ **Yes** ❒ Work Related ❒ Auto accident
❒ Other (Explain) ______

Do you have legal action pending regarding this? ❒ **No** ❒ **Yes** Attorney Name & Phone

Date	Area	DOI	Chart

DPH DMO RAB DJW MAW MSD GRB WAS

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 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 to release my medical records to any other physicians/medical facilities directly involved in my care, and for the purpose of administering claims. I have been made aware of Arizona Orthopaedic Associates' Notice of Privacy Practices and Financial Policy. I hereby authorize the assignment of payment of my medical benefits to Arizona Orthopaedic Associates at Gateway. 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 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.

Patient/Parent/Guardian Signature______________________ **Date**__________

PATIENT INFORMATION - MINOR