Arizona Orthopedic & Fracture Surgeons

PATIENT REGISTRATION FORM

PATIENT INFORMATION

*Name:*____ *Date of Birth:* ______/______/______ *Age:* __________

*Address:*____ *Social Security #* ________________________________

City: ____ *Driver's License #* ________________________________

State: _______________________ *Zip:* ______________ *Occupation:* ______________________________________

Phone Number : (______) ______________________________ *Employer:* ______________________________________

Work Phone Number : (_______) ________________________ *Martial Status: S M Div. Sep. Widowed*

E-mail Address: ______________________________________ *Referring Phys./PCP:* ______________________________

Date of Injury/Symptoms: _______/_______/___________ *How did you hear about us?* _______________________

Responsible Party Information

*Name:*____ *Relationship:* __________________________________

Address : ____ *Soc. Security #* ________________________________

City, State, Zip: _____________________________________ *Date of Birth:* _______/_______/________

Phone: (_____) _______________________________________ *Work Phone : (_____)* __________________________

Emergency Contact Information

Name: ____

Relationship: ____ *Phone: (_____)* _________________________________

Address: ____ *Work Phone: (_____)* ____________________________

City, State ,Zip: _____________________________________ *Pager: (_____)* _________________________________

Insurance Information

Primary Insurance:	*Secondary Insurance:*
Ins. Co. Name: ______________________________	*Ins. Co. Name:* ______________________________
Ins. Co. Address: ____________________________	*Ins. Co. Address:* ____________________________
Ins. Co. Phone: (______) ______________________	*Ins. Co. Phone: (______)*______________________
Subscriber's Name: ___________________________	*Subscriber's Name:* ___________________________
Subscriber's SS # _____________________________	*Subscriber's SS #*_____________________________
*Subscriber's ID #*_____________________________	*Subscriber's ID #* _____________________________
*Subscriber's Group #*__________________________	*Subscriber's Group#*__________________________
Gender Male Female	*Gender Male Female*
Relationship to Patient: _______________________	*Relationship to Patient:* _______________________
Date of Birth: _______/________/____________	*Date of Birth:* _______/________/____________
Insured's Employer: __________________________	*Insured's Employer:* __________________________

AUTHORIZATION TO RELEASE INFORMATION: *I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health. These records can be transmitted by fax.*

AUTHORIZATION TO PAY*: I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, payable to me for services. I understand that am financially responsible for the charges not covered by my insurance.*

PATIENT SIGNATURE: ____ *Date:* ____________________________