OrthoArizona

PATIENT GENERAL INFORMATION

Patient name: *(First, Middle, Last)* _____

Preferred name: *(optional)* _____ **Date of birth:** _____/_____/_____ (month / day / year)

Sex: Male / Female / Unidentified **Marital status:** Single / Married / Widowed / Separated / Divorced

Primary address: _____ **City:** _____ **State:** ____ **Zip:** _____

Secondary address: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell phone: (_____)_____ **Home phone:** (_____)_____ **Work phone:** (_____)_____

E-Mail: _____ **Preferred contact method:** Cell / Home / Work / E-Mail

Would you like to be registered for our Patient Portal to view your medical information? ***(email required)*** Yes / No

May we leave a voice message? Yes / No **Preferred language:** English / Spanish / Other:_____

Employment status: Employed / Retired / Unemployed **If "Employed", occupation:**_____

Race / Ethnicity: White / Hispanic / African American / Asian / Native American / Other_____

Primary physician: *(blank if none)* _____ **Referring physician:** *(blank if none)* _____

Emergency contact name: _____ **Relationship:** _____ **Phone #:** (____)_____

Preferred pharmacy: _____ **Major crossroads:** _____

Pharmacy phone #: *(optional)* (____)_____ **Pharmacy address:** ***(optional):*** _____

PRIMARY Insurance Policy holder? Self / Spouse / Child / Other **Primary Insurance Company:** _____

If PRIMARY policy holder is NOT "Self", Holder Name: _____ **Date of birth:** ____/____/____

SECONDARY Insurance Policy holder? Self / Spouse / Child / Other **Secondary Insurance Company:** _____

If SECONDARY policy holder is NOT "Self", Holder Name: _____ **Date of birth:** ____/____/____

Is this injury related to an accident? Yes / No **If "Yes",** Work Related / Auto Accident / Other:_____

If "Work Related", Employer: _____ **Social Security #** ____-____-____

Legal action pending for this injury? Yes / No **If "Yes", Attorney Name**:_____ **Phone:** _____

GUARANTOR (Person responsible for the non-insurance covered medical expenses. Can not be a minor or incapacitated adult)

Social Security # of Guarantor: _____ - ____- _____ **Is Guarantor the patient?** Yes / No If "Yes", skip to next section

Guarantor name: *(First, Last)* _____ **Phone:** (_____)_____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

List persons authorized to discuss your protected health information with our staff and/or pick up prescriptions, x-rays, lab slips. *(optional)*

Name:_____ **Relationship:**_____ **Phone #:** (____)_____

Name:_____ **Relationship:**_____ **Phone #:** (____)_____

- **I AUTHORIZE AND REQUEST ORTHOARIZONA AND ITS DIVISIONS TO:**
  - **PERFORM DIAGNOSTIC PROCEDURES AND TREATMENTS AS MAY BE NECESSARY FOR PROPER MEDICAL CARE.**
  - **RELEASE MY MEDICAL RECORDS TO ANY OTHER PHYSICIAN OR MEDICAL FACILITIES DIRECTLY INVOLVED IN MY CARE AND FOR THE PURPOSE OF ADMINISTERING CLAIMS AND TO OBTAIN MEDICATION HISTORY FOR THE PURPOSE OF TREATMENT.**
  - **ASSIGN PAYMENT OF MY MEDICAL BENEFITS TO ORTHOARIZONA.**

I HAVE BEEN MADE AWARE OF AND UNDERSTAND ORTHOARIZONA'S: NOTICE OF PRIVACY PRACTICES, PATIENT FINANCIAL POLICY, NOTICE TO PATIENTS AND ACO BENEFICIARY NOTICE. THE NOTICE TO PATIENTS DISCLOSES THAT ORTHOARIZONA PROVIDERS HAVE A DIRECT FINANCIAL INTEREST IN SEPARATE DIAGNOSTIC OR TREATMENT AGENCIES OR IN NONROUTINE GOODS OR SERVICES THAT THE PATIENT IS BEING PRESCRIBED AND THAT PRESCRIBED TREATMENTS, GOODS OR SERVICES ARE AVAILABLE ON A COMPETITIVE BASIS. THE ACO BENEFICIARY NOTICE STATES THAT ORTHOPEDIC SPECIALISTS OF NORTH AMERICA, PLLC (ORTHOARIZONA) IS PARTICIPATING IN A MEDICARE SHARED SAVINGS PROGRAM ACCOUNTABLE CARE ORGANIZATION.

PATIENT / PARENT / GUARDIAN SIGNATURE: _____ **TODAY'S DATE:** _____/_____/_____ (month / day / year)