OrthoArizona
Canyon Orthopaedic Surgeons

Welcome to our Office

Southwest	Northwest
10450 W Mcdowell Rd, Ste 102 Avondale, AZ, 85392	6760 W Thunderbird Rd, Ste E110 Peoria, AZ, 85381

General Patient Information

(This information is necessary for our files and will be considered confidential) Date:_____

_____ Last Name | _____ First Name | _____ Middle | (____)_____ Phone Number

_____ Address | _____ City | _____ State | _____ Zip Code

Sex: ☐ Male ☐ Female

_____ Social Security Number | _____ Date of Birth | _____ Age

Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Preferred Language: ☐English ☐Spanish ☐Other:_____

Race: ☐White/Caucasian ☐Hispanic ☐African American ☐Asian ☐Native American

_____ Primary Care Physician

_____ Referred By

_____ Email

Emergency Contact

_____ Name | _____ Relationship | (____)_____ Phone Number

Primary Insurance Information

_____ Insurance Company Name | _____ Policy Holder's Name | _____ Policy Holder's DOB | _____ Policy #

_____ Group # | _____ Social Security **if Different than Patient** | Patient Relation to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other_____

Secondary Insurance Information

_____ Insurance Company Name | _____ Policy Holder's Name | _____ Policy Holder's DOB | _____ Policy #

_____ Group # | _____ Social Security **if Different than Patient** | Patient Relation to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other_____

Preferred Pharmacy Information

_____ Preferred Pharmacy Name | _____ Pharmacy Address *Approximate Crossroads if address unknown

(____)_____ Pharmacy Phone Number

☐ *If no preferred pharmacy, please check box and physician will choose pharmacy

If Patient is a Minor or Student

_____ Responsible Party | _____ Relationship | _____ DOB | _____ Social Security Number

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 OrthoArizona at Canyon Orthopaedic Surgeons, **to release/attain my medical records to/from any other physician/medical facilities directly involved in my care**, and for the purpose of administering claims. I have been made aware of COS's **Notice of Privacy Practices** and **Financial Policy**. I hereby authorize the assignment of payment of my medical benefits to Canyon Orthopaedic Surgeons. I understand I may receive services or supplies that are not covered by my insurance plan on date of service and I agree to be directly responsible for these expenses. I understand copays and deductibles are due at time of service. I understand that it is ultimately my responsibility to ensure that the physician I will be seeing is contracted with my insurance plan. Delinquent accounts may be referred to a collection agency for payment. Associated collection agency costs will be your responsibility.

Patient/Guardian Signature:_____ **Date:**_____

Revised: 02/2016