

SPOUSE INFORMATION

Name: _____ SSN: _____ DOB: _____

Employer: _____ Work Phn: _____

GUARDIAN / PARENT INFORMATION IF PATIENT IS A MINOR
Mother Father

Name : _____

SSN : _____

Address (if Different from Above) _____

Home Ph: _____

Work Ph: _____

CHECK-OUT NOTE

PLEASE PRESENT YOUR INS CARD AND A PICTURE ID AT THE FRONT DESK.

PLEASE STOP at the CHECK-OUT COUNTER before leaving our office. Payment for office services is due on the day of service. As part of our service we will submit your insurance claims. Insurance/Financial arrangements should be made with our patient relations dept prior to SURGERIES.

RELEASE OF INFORMATION and ASSIGNMENTS OF BENEFITS DECLARATION

I hereby authorize release of any medical information necessary to process my insurance claims. Furthermore, I irrevocably ASSIGN to ORTHOPEDICS OF N SCOTTSDALE and/or its DOCTORS any and all payments from my Insurance(s) for services rendered. I understand and agree to the above conditions. This authorization can only be revoked in writing. A copy of this authorization shall be as valid as the original.

Signature

Relationship to Patient: _____