

Desert Orthopedic Specialists

Patient Name _____ Date _____

Date Of Birth ____ / ____ / ____ Age ____ SSN# ____ / ____ / ____

Address _____
(City) (State) (Zip)

HM Phone _____ WK Phone _____ Other Phone _____

Marital Status **M** **S** **D** **W** Spouses Name _____

Primary Care Physician _____ Phone _____

How did you hear about our office? _____

In Case Of Emergency, Please Notify: _____

Relationship _____ HM Phone _____ WK Phone _____

EMPLOYER

Employer Name _____ Occupation _____

Address _____ Phone _____

INSURANCE AND PAYMENT INFORMATION

Primary Insurance

Insured's Name _____ Date Of Birth _____ SSN _____

Insurance Name _____ ID# _____ GRP# _____

Address _____ Phone _____
(City) (State) (Zip)

Employer Name _____ Phone _____

Secondary Insurance

Insured's Name _____ Date Of Birth _____ SSN _____

Insurance Name _____ ID# _____ GRP# _____

Address _____ Phone _____
(City) (State) (Zip)

Employer Name _____ Phone _____

INITIAL

Authorization of Benefits and to Release Information: I hereby authorize insurance payment to Desert Orthopedic Specialists and the release of any information to my insurance company acquired in the course of examination or treatment. If my account should become delinquent I will be responsible for the collection administration fee up to 35% of total charges.

INITIAL

Treatment Authorization: I hereby authorize treatment of the above named patient and agree to accept responsibility for any charges incurred by services rendered through Desert Orthopedic Specialists.

INITIAL

Insurance and Payment Policy: Payment for our office services is required at each visit. Co-payments must be paid when checking out. We will file insurance for hospitalization, surgery and authorized work related injuries and allow (60) days for the insurance company to pay these claims. Thereafter, the payment on the account is due.

Patient / Guardian Signature _____ Date _____

(If Patient Is Under 18 Parent/Guardian Must Sign Form)