

Today's Date: \_\_\_\_\_ Account #: \_\_\_\_\_

(Office use only)

**Patient Information**

Patient's Full Legal Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Sex: M F Age: \_\_\_\_\_ Patient's SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

**Responsible Party Information**

Guarantor/Responsible Party: \_\_\_\_\_ Responsible party SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

**Referral Information**

Referred to this office by: \_\_\_\_\_

Name of Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for today's exam: \_\_\_\_\_ Date of injury/accident: \_\_\_\_\_

Part of Body: \_\_\_\_\_ Right side: Left side:

Were you injured on the job: Yes No In an accident: Yes No

**Primary Insurance Information**

Primary Insurance: \_\_\_\_\_

Cardholder/subscriber: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Cardholder's date of birth: \_\_\_\_\_ Cardholder's SSN: \_\_\_\_\_

Employer's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Co-pay amount: \$ \_\_\_\_\_

**Secondary Insurance Information**

Secondary Insurance: \_\_\_\_\_

Cardholder/subscriber: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Cardholder's date of birth: \_\_\_\_\_ Cardholder's SSN: \_\_\_\_\_

Employer's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Co-pay amount: \$ \_\_\_\_\_

**CONSENT TO TREAT**

I consent to treatment by my primary Tucson Orthopaedic Institute (TOI), physician \_\_\_\_\_  
M.D. I am aware if my primary TOI physician is unavailable, I will be seen and treated by another TOI  
Physician providing coverage for the Tucson Orthopaedic Institute, P.C. physicians.

Agree      Disagree

**PAYMENT POLICIES/INSURANCE RELEASE**

It is my responsibility to pay the doctor for his services provided by Tucson Orthopaedic Institute. Payment is due when services are rendered. This office will file insurance for all Medicare services, Workman's Compensation, all contracted insurance carriers and all surgical services. I authorize release of medical information for my insurance claims or legal purposes and authorize payment of insurance benefits to Tucson Orthopaedic Institute, P.C. I understand that I am responsible for all charges not covered by insurance. I am responsible for attorney fees incurred for collections purposes.

Agree      Disagree

Patient Signature \_\_\_\_\_ (for later use)