



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: _____ Email: _____
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: \$ _____

Patient Signature _____ (for later use)

Patient's Full Legal Name: _____ Birthdate: _____

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)