

SOUTHWEST ORTHOPAEDIC SURGERY SPECIALISTS, PLC.
ANKLE & FOOT CENTER • SPORTS MEDICINE CENTER

Print

PATIENT INFORMATION RECORD

Today's Date: _____

Patient's Name: _____
Last First MI

Address: _____
Street

_____ City State Zip Code

Home Phone: (_____) _____ Work: (_____) _____ Cell: (_____) _____
(Please circle best number to reach you during the day)

E-Mail Address: _____ Sex: M F

Birth Date: ____/____/____ SS #: ____/____/____ Marital Status: _____

Patient's Employer: _____
Name Address Phone

Patient's Occupation: _____

Referred By: _____

Spouse/Parent/Guardian Name: _____

Employer: _____

Employer Address: _____

EMERGENCY CONTACT:

Person to Call: _____ Relationship to Patient: _____

Phone: (_____) _____

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INSURANCE INFORMATION:

Primary Insurance Carrier: _____ Phone: (_____) _____

Carrier Address: _____
Street City State Zip

Policy Holder / Subscriber: _____ Relationship to Patient: _____

Birth Date: ____/____/____ SS #: ____/____/____ Employer: _____

Policy #: _____ Group #: _____ Effective Date: ____/____/____

Secondary Insurance Carrier: _____ Phone: (_____) _____

Carrier Address: _____
Street City State Zip

Policy Holder / Subscriber: _____ Relationship to Patient: _____

Birth Date: ____/____/____ SS #: ____/____/____ Employer: _____

Policy #: _____ Group #: _____ Effective Date: ____/____/____

Workers Compensation: _____ Phone: (_____) _____

Adjuster's Name: _____ Claim #: _____ Date of Injury: ____/____/____

PLEASE PRESENT YOUR INSURANCE CARDS TO THE RECEPTIONIST SO THAT
WE MAY HELP YOU WITH YOUR INSURANCE REIMBURSEMENT

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REASON FOR VISIT:

Briefly describe the reason for your visit to Southwest Orthopaedic Surgery Specialists, PLC. Include date of injury if applicable. _____

PHYSICAL HISTORY:

Primary Care Physician: _____

Height: _____ Weight: _____ Date of Last Physical Exam: ____/____/_____

Medical Allergies: _____

Are You Currently Under a Doctor's Care? Yes No

If yes, please describe: _____

Do you smoke? Yes No

If yes, how much do you smoke per day? _____

Do you drink alcoholic beverages? Yes No

If yes, how often and how much do you drink? _____

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CURRENT MEDICATIONS:

Describe all medications that you are currently taking, the dose that you take, and when (how often) you take it. Please include all prescription drugs and over-the-counter, non-prescription drugs that you are currently taking.

Medication Name: _____ Dose: _____ When Taken: _____

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DIETARY SUPPLEMENTS:

Some dietary supplements, including certain herbs, may cause complications with some medical procedures. If you take nutritional supplements, such as vitamins, minerals, herbs and dietary oils, please list them here.

Supplement Name: _____ Dose: _____ When Taken: _____

Supplement Name: _____ Dose: _____ When Taken: _____

If you need more space, use the back of this page to continue your list of medications and supplements.

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize Southwest Orthopaedic Surgery Specialists to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to Southwest Orthopaedic Surgery Specialists. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

ASSIGNMENT OF MEDIGAP BENEFITS:

I authorize payments of benefits from my MEDIGAP carrier directly to Southwest Orthopaedic Surgery Specialists. This assignment of benefits is considered in force from the date of signing until revoked in writing.

MISSED APPOINTMENTS:

When a patient fails to keep an appointment, we have the right to charge a fee for the missed appointment. To avoid missed appointment fees, the patient must notify Southwest Orthopaedic Surgery Specialists in advance of the scheduled appointment time. The price for missed appointments is \$35.00. Insurance companies do not pay missed appointment charges. Appointment cancellations should be made at least four hours before the scheduled appointment time, and when possible, 24 hours in advance. We are aware that emergencies do arise. Please, call our office in Tucson, AZ at (520) 327-9677, if you cannot make an appointment.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and completed the requested information to the best of my ability.

Patient Name (Please PRINT Full Name)

Date

Patient Signature

Sign and date below for a patient that is a minor:

Parent/Guardian Name (PRINT Name)

Date

Signature of Parent or Legal Guardian