

Joint Replacement Center Of Scottsdale

10250 N 92nd Street
 Scottsdale, AZ 85258-6704
 (480) 237-5727



PATIENT INFORMATION					
NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)			
CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE		
PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN			
PRIMARY EMPLOYER		SECONDARY EMPLOYER (if Applicable)			
ADDRESS		ADDRESS			
CITY, STATE ZIP		CITY, STATE ZIP			
WORK PHONE		WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)				
NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)		
CITY, STATE ZIP		CITY, STATE ZIP		
HOME PHONE		HOME PHONE		
RELATIONSHIP TO PATIENT				

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
CITY, STATE ZIP		DEDUCTIBLE	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)			
NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
CITY, STATE ZIP		DEDUCTIBLE	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted and I will be bound by the signature as though I personally signed the claim. I also authorize the release of any med-agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

 SIGNATURE OF PATIENT/GUARDIAN

 DATE