

**PHOENIX ORTHOPAEDIC CONSULTANTS**

(602) 298-8888

5605 W. Eugie Ave., Ste. 111  
Glendale, AZ 85304

18699 N. 67th Ave., Ste. 120  
Glendale, AZ 85308

**Patient Information Record**

|  |                |   |  |
|--|----------------|---|--|
| Patient Name _____                                     |                | Email _____                               |  |
| Address _____  |                | City _____                                | State _____ Zip _____                          |
| Out of State Address _____                             |                | City _____                                | State _____ Zip _____                          |
| Date of Birth ____/____/____                           | Age _____      | Gender _____ M _____ F                    | Marital Status _____ S _____ M _____ W _____ D |
| Social Security No. _____ - _____ - _____              |                | Phone _____                               | Cell Phone _____                               |
| Employer _____   |                | Occupation _____                          | Phone _____                                    |
| Address _____  |                | City _____                                | State _____ Zip _____                          |
| Patient's Primary Care Physician _____                 |                | Phone _____                               |  |
| Address _____  |                | City _____                                | State _____ Zip _____                          |
| Referred by _____                                      |                | Phone _____                               |  |
| Emergency Contact _____                                |                | Relationship _____                        |  |
| Address _____  |                | Phone _____                               |  |
| Spouse (or Parent, if minor) _____                     |                |   |  |
| Date of Birth ____/____/____                           |                | Social Security No. _____ - _____ - _____ |  |
| Address _____  |                | City _____                                | State _____ Zip _____                          |
| Employer _____   |                | Occupation _____                          | Phone _____                                    |
| Primary Insurance Company _____                        |                | Phone _____                               |  |
| Address _____  |                | City _____                                | State _____ Zip _____                          |
| ID # _____   | Policy # _____ | Group # _____                             |  |
| Policy Holder's Name _____                             |                | Date of Birth ____/____/____              |  |
| Policy Holder's Address (if other than patient) _____  |                | Phone _____                               |  |
| Policy Holder's Employer (if other than patient) _____ |                | Phone _____                               |  |
| Address _____  |                | City _____                                | State _____ Zip _____                          |
| Policy Holder's Relationship to Patient _____          |                |   |  |
| Secondary Insurance Company _____                      |                | Phone _____                               |  |
| Address _____  |                | City _____                                | State _____ Zip _____                          |
| ID # _____   | Policy # _____ | Group # _____                             |  |
| Policy Holder's Name _____                             |                | Date of Birth ____/____/____              |  |
| Policy Holder's Address (if other than patient) _____  |                | Phone _____                               |  |
| Policy Holder's Employer (if other than patient) _____ |                | Phone _____                               |  |
| Address _____  |                | City _____                                | State _____ Zip _____                          |
| Policy Holder's Relationship to Patient _____          |                |   |  |
| Secondary Insurance Company _____                      |                | Phone _____                               |  |

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS:**

I hereby authorize and assign payment of medical benefits to the provider of services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature will bind me as though I personally signed each claim. I also authorize the release of any medical information necessary. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES. If my account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date