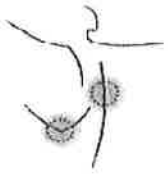
Joint Replacement Center Of Scottsdale

20401 N. 73rd St., Ste 160
Scottsdale, AZ 85255
Phone: 480-237-5727
Fax: 480-657-3207



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