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PATIENT INFORMATION

PATIENT NAME Last	First	M.I.	SOCIAL SECURITY NUMBER
ADDRESS Street			DATE OF BIRTH / SEX ☐ Female ☐ Male
City	State	Zip / HOME PHONE NO.	MARITAL STATUS ☐ Single ☐ Divorced ☐ Married ☐ Widowed
EMPLOYER			EMPLOYER PHONE NO.
EMPLOYER ADDRESS			PATIENT'S OCCUPATION

PERSON RESPONSIBLE FOR CHARGES

If person responsible for payment is different from patient, then complete below.
If patient is a child please indicate if parents are: ☐ Married ☐ Separated ☐ Divorced

NAME	SOCIAL SECURITY NUMBER
ADDRESS Street	DATE OF BIRTH
City State Zip	HOME PHONE NO.
EMPLOYER	EMPLOYER PHONE NO.
EMPLOYER ADDRESS	

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN	NAME OF REFERRING PHYSICIAN

EMERGENCY INFORMATION

IN CASE OF EMERGENCY NOTIFY NAME	PHONE
ADDRESS	

INSURANCE INFORMATION

FOR OFFICE USE ONLY

I hereby authorize Arizona Arthritis & Rheumatology Associates, P.C. to release any information in the course of my examination and/or treatment as permitted by law to facilitate treatment, payment, or healthcare. I hereby authorize payment directly to Arizona Arthritis & Rheumatology Associates, P.C. for surgical and medical benefits, if any, otherwise payable to me under terms of my insurance. I hereby authorize photocopies of this to be as valid as the original.

I am financially responsible for all non-covered services, insurance denials and all services rendered without a referral, if my plan requires a referral for services rendered.

I hereby agree to immediately pay all statements received from Arizona Arthritis & Rheumatology Associates, P.C. for services rendered. I agree to pay interest on all past due accounts (over thirty days) at the rate of 1.5% per month/18% per annum, if it becomes necessary to put my account in the hands of a collection agency or attorney. I also agree to pay all such costs of collection and reasonable attorney's fees incurred.

SIGNED _____ DATE _____

PLEASE COMPLETE THIS PATIENT INFORMATION AND AS MUCH OF THE ATTACHED MEDICAL HISTORY AS POSSIBLE BEFORE OFFICE VISIT.