Arizona Community Surgeons, P.C.

PATIENT REGISTRATION

ACS West Campus • Arizona Orthopedics & Joint Replacement Center • Institute for Plastic Surgery
Hess & Sandeen Plastic Surgery • Southern Arizona Center for Minimally Invasive Surgery • Southern Arizona Orthopedics
Southwestern Surgery Associates • Tucson Surgical Specialists • University Orthopedic Specialists

PATIENT INFORMATION – PLEASE MAKE SURE EVERY LINE IS COMPLETE

Patient Name: _____ Birth Date: _____ Age: _____
Last First MI Nickname

Address: _____
Street City State Zip Code

Primary Phone #: _____ Cell Phone #: _____ Social Security #: _____

E-mail address: _____ Sex: ◯ Male ◯ Female

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed Spouse Name: _____

Race: _____ Ethnicity: ◯ Hispanic ◯ Non-Hispanic Preferred Language: _____

Referred by: _____ Family Physician: _____

Employer: _____ Occupation: _____ Employer Phone #: _____

In case of emergency, notify: _____ Phone #: _____ Relationship: _____

Person responsible for bill, if other than the patient: _____ Phone #: _____

Responsible person's Employer: _____ Responsible person's Social Security #: _____

We will be prescribing medications electronically and need your permission to access your prescribed medications to avoid drug interactions and duplication. Your signature below will act as permission. Please provide your preferred pharmacy information:

Pharmacy Name/Cross Streets <u>OR</u> Address/Phone #:

_____

_____

INSURANCE INFORMATION – PLEASE GIVE YOUR INSURANCE CARDS TO RECEPTIONIST FOR SCANNING

Primary Insurance: _____ ID #: _____ Group #: _____

Insured Person's Name: _____ Birth Date: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Insured Person's Name: _____ Birth Date: _____

Do you have AHCCCS? ◯ Yes ◯ No Is this visit due to an injury on the job? ◯ Yes ◯ No Date of Injury: _____

Employer at time of injury: _____ ***You must provide billing information from your employer.***

I attest that the information provided above is true and accurate. I acknowledge that I have read, signed and will abide by the Arizona Community Surgeons, P.C. "Patient Payment and Financial Policies".

Patient's Signature: _____ Date: _____
(or Parent/Guardian if patient is a minor)