

PATIENT # _____

WELCOME TO OUR OFFICE

NEW UPDATE

MEZONA ORTHOPAEDIC PROFESSIONAL ASSOCIATION
2940 E. Banner Gateway Dr., Suite 200
Gilbert, AZ 85234
(480) 964-2908

- RALPH V. WILSON, M.D.
- DWIGHT S. KELLER, M.D.
- KIPLING P. SHARPE, M.D.
- MARC I. DINOWITZ, M.D.
- MAXWELL THOMAS, M.D.
- DANIEL J. MULLEN, M.D.
- CYNTHIA L. KOOIMA, M.D.

GENERAL PATIENT INFORMATION

(This information is necessary for our files and will be considered confidential)

(Please check what type of phone #)

Date _____ Phone # our office may contact you at 1 () _____
 HOME WORK CELL

PATIENTS LAST NAME _____ FIRST NAME _____ MIDDLE _____ 2 () _____
 HOME WORK CELL

LOCAL ADDRESS _____ APT/LOT# _____ CITY _____ STATE _____ ZIP _____

PERMANENT ADDRESS (If Different than Local Address) _____ PHONE _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____ AGE _____ SEX: MALE FEMALE
 PRIMARY CARE PHYSICIAN & PHONE # _____

MARITAL STATUS SINGLE MARRIED WIDOWED SEPARATED DIVORCED
 ADDRESS _____

EMPLOYED BY _____ WORK PHONE _____

EMPLOYER'S ADDRESS _____ OCCUPATION _____

SPOUSE INFORMATION

NAME _____ DATE OF BIRTH _____ SS# _____

SPOUSES EMPLOYER _____ ADDRESS _____ WORK PHONE _____

IN CASE OF EMERGENCY

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY OTHER THAN SPOUSE _____ RELATIONSHIP _____ () _____
 EMERGENCY PHONE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

IF THE PATIENT IS A MINOR OR STUDENT

RESPONSIBLE PARTY _____ RELATIONSHIP _____ D.O.B. _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ S.S.# _____

EMPLOYER _____ ADDRESS _____ OCCUPATION _____ WORK PHONE _____

INSURANCE INFORMATION

INSURANCE COMPANY NAME _____ PHONE _____ IS THIS THROUGH EMPLOYER YES NO

ADDRESS _____

EFFECTIVE DATE _____ GROUP NUMBER _____

POLICY HOLDER'S NAME _____ POLICY HOLDER S.S.# _____ D.O.B. - POLICY HOLDER _____ INSURED'S I.D. NUMBER (Policy No.) _____

CO-PAY _____ SUBSCRIBER'S RELATIONSHIP TO PATIENT: SELF SPOUSE _____

SECONDARY INSURANCE

SECONDARY INSURANCE COMPANY NAME _____ PHONE _____ IS THIS THROUGH EMPLOYER YES NO

ADDRESS _____

EFFECTIVE DATE _____ GROUP NUMBER _____

POLICY HOLDER'S NAME _____ POLICY HOLDER S.S.# _____ D.O.B. - POLICY HOLDER _____ INSURED'S I.D. NUMBER (Policy No.) _____

CO-PAY _____ SUBSCRIBER'S RELATIONSHIP TO PATIENT: SELF SPOUSE _____

SEE REVERSE SIDE

- I understand that I am responsible for any patient responsibility not contractually covered by my insurance company's agreement with Mezona Orthopaedic Professional Association.
- I hereby authorize Mezona Orthopaedic Professional Assoc. to release to all my insurance carriers or their representatives, any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I authorize my doctor or his representative to act as my agent in helping me obtain payment from my insurance carriers. This includes treatment for drug, alcohol, mental health, and AIDS related conditions.
- I authorize and request my insurance company to pay directly to Mezona Orthopaedic, P.A. the amount due me in my pending claim for medical, major medical or surgical treatment or services by reason of such treatment or services rendered.
- I understand that if my Mezona Orthopaedic Professional Assoc. financial account needs collection, all collection fees will be added to the original balance.

Signature of patient (I have read and understand all of the above information) _____ Date _____

If under 18, responsible party signature _____ Relation _____