

ARIZONA ASSOCIATED SURGEONS, PLLC

- Charles E. Castillo, MD
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 Brett I. Siegrist, MD
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 David C. Johnson, MD
 Edward H. Charles, MD
 Douglas J. Carlon, MD
 Adrienne W. Forstner-Barthell, M.D.
 Keith G. Zacher, MD
 Jeromy S. Brink, MD

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY #
HOME ADDRESS			CITY	STATE	ZIP
			SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
HOME PHONE #	WORK PHONE #	CELL PHONE #		MARRIED STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	
			<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> OTHER		
SPOUSE NAME:			SPOUSE DOB:		
REFERRING PHYSICIAN NAME AND ADDRESS AND ZIP				REFERRING PHYSICIAN PHONE#	

RESPONSIBLE PARTY INFORMATION (financial responsibility)

LAST NAME	FIRST NAME	MI	HOME PHONE	
ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #
EMPLOYER	OCCUPATION		WORK PHONE	
EMPLOYER ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY
<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER				

PATIENT EMPLOYMENT INFORMATION (if other than responsible party)

PATIENT'S EMPLOYER	OCCUPATION	WORK RELATED <input type="checkbox"/> Yes <input type="checkbox"/> No
EMPLOYER ADDRESS		CLAIM # FOR WORKER'S COMP/ICA
CITY	STATE	ZIP
		DATE OF INJURY

EMERGENCY INFORMATION

NEXT-OF-KIN OR CONTACT INFO – OTHER THAN SPOUSE			RELATIONSHIP
ADDRESS	CITY	STATE	ZIP
			PHONE

INSURANCE INFORMATION-SUBSCRIBER PARTY INFORMATION

PRIMARY INSURANCE	SUBSCRIBER NAME AND SOCIAL SECURITY	DATE OF BIRTH
GROUP NUMBER	IDENTIFICATION NUMBER	
ADDRESS	CITY	STATE
		ZIP
		PHONE
SECONDARY INSURANCE	SUBSCRIBER NAME AND SOCIAL SECURITY	DATE OF BIRTH
GROUP NUMBER	IDENTIFICATION NUMBER	
ADDRESS	CITY	STATE
		ZIP
		PHONE NUMBER

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE**ASSIGNMENT OF BENEFITS**

I understand I am financially responsible for services rendered regardless of insurance or other third party payer. Unpaid balance subject to collection fees of 30%, as well as legal fees if applicable. Also, I understand that I may be financially responsible for a surgery cancellation fee of up to \$150 should I fail to cancel/reschedule at least **24 hours in advance**.

I hereby authorize direct payment to Arizona Associated Surgeons PLLC of any medical benefits payable to me for the services provided at Arizona Associated Surgeons. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done.

X _____
 Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE

I hereby authorize Arizona Associated Surgeons PLLC to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

X _____
 Patient Signature or Signature of Guardian or Parent Date

INFORMATION CONFIRMED BY STAFF: _____

INSURANCE CARD SCANNED: _____