TRI STATE ORTHOPEDIC

2000 Highway 95, Suite 200

Bullhead City, AZ 86442

(928) 758-1175

(928) 758-5191 (fax)

Patient Name:_____ o Male o Female

Mailing Address:_____

_____

Phone Number: ( )_____ Home

( )_____ Cell

( )_____ Work

Email Address:_____

Would you like to be enrolled in our patient portal? YES NO

Patient Date of Birth:_____

Patient Country of Birth:_____

Preferred Language:_____

Emergency Contact:_____Phone:_____

Employer:_____ Occupation:_____

Address and Phone Number:_____

Insurance Carrier(s):_____

Social Security Number:_____(if VA patient this is required)

Name of Policy Holder if NOT patient:_____

Policy Holder Date of Birth:_____ Relationship to Patient:_____

_____(Initial) I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Tri State Orthopedic (TSO) to apply for benefits on my behalf for covered services rendered by the medical providers that belong to TSO. I request that payment from my insurance company be made directly to TSO. I fully certify that the information I have reported regarding my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

_____ _____

Patient Signature/Authorized Signature DATE