

# Steingart Orthopedics, P.C.

## Acct # \_\_\_\_\_ PATIENT INFORMATION SHEET

\*\*\* Please Print & Complete Everything Today's Date \_\_\_\_\_

Patient's full name \_\_\_\_\_ Birth Date \_\_\_\_\_ AGE \_\_\_\_\_

Current address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City State Zip

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Other \_\_\_\_\_ SS# \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City State Zip

Parent or Spouse's full name \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date \_\_\_\_\_

Parent or Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City State Zip

Referred by: \_\_\_\_\_

### RELATIVE WHOM WE MAY CONTACT IN THE EVENT OF AN EMERGENCY:

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Area of Complaint? \_\_\_\_\_

Sports injury? \_\_\_ Yes \_\_\_ No Work injury? \_\_\_ Yes \_\_\_ No Auto Accident? \_\_\_ Yes \_\_\_ No School injury? \_\_\_ Yes \_\_\_ No

Date of injury: \_\_\_\_\_ Student? \_\_\_ Yes \_\_\_ No if yes \_\_\_\_\_ full-time \_\_\_\_\_ part-time

Smoker? \_\_\_ Yes \_\_\_ No Allergies? \_\_\_\_\_ Dominant Hand? \_\_\_ Right \_\_\_ Left

### INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_ Effective Date \_\_\_\_\_

Address \_\_\_\_\_ Insured Party \_\_\_\_\_  
City State Zip

ID # \_\_\_\_\_ GRP # \_\_\_\_\_ Type of Coverage \_\_\_\_\_

Phone # \_\_\_\_\_

Deductible Co-pay \$ \_\_\_\_\_ Satisfied \_\_\_\_\_ O.O.P. \_\_\_\_\_ Accident coverage \_\_\_\_\_ Percent. for Radiology, Braces, etc. \_\_\_\_\_

### SECONDARY INSURANCE

Insurance Company Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Insured Party \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Insured Party \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

(OVER)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Account # \_\_\_\_\_

### AUTHORIZATION

I hereby authorize STEINGART ORTHOPEDICS to release any information acquired in the course of my examination or treatment.

I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical care and treatment to STEINGART ORTHOPEDICS.

I hereby authorize photocopies of this form and my signature to be as valid as the original.

I hereby authorize payment directly to STEINGART ORTHOPEDICS for the surgical and/or medical benefits, if any, otherwise payable to me under terms of my insurance.

If eligibility of insurance cannot be verified, or if deductible has not been met, I understand that I will be responsible for the cost of all medical services rendered.

I agree to pay any collection costs and/or attorney fees as may be required to effect collection of charges incurred.

DATE: \_\_\_\_\_ SIGNATURE \_\_\_\_\_

### CONSENT FOR TREATMENT OF MINOR

I hereby give my consent for the attending physician to render medical treatment, as deemed necessary to my child,

\_\_\_\_\_  
Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Witness

### AUTHORIZATION RECEIVED BY PHONE

Parent or Guardian: \_\_\_\_\_

Witness: \_\_\_\_\_

Witness: \_\_\_\_\_

**STEINGART ORTHOPEDICS, P.C.**

MICHAEL A. STEINGART, D.O.  
ORTHOPEDIC SURGERY \* BOARD CERTIFIED

16601 North 40th Street, Suite 210, Phoenix, AZ 85032 • 602-923-8500, Fax 602-923-8502