Stuart C. Kozinn MD

Scottsdale Joint Center

Gregory T. Evangelista MD

Patient Information

Date_____

Name: Last, First, MI_____

Address: _____City:_____State:_____Zip_____

Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Date of Birth: _____ Age_____ Social Security Number: _____ Email_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced – Date of Injury_____

Occupation: _____ Employed by: _____

Who is your Primary Care Doctor? _____ Who may we thank for referring you?_____

Person to contact in case of emergency_____ Phone_____

Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Phone (____)_____
Address: _____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address: _____ Ins Co. Phone #_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING
Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____)_____
Address of Employer: _____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address: _____ Ins Co. Phone: _____

If this is a Workmen's Compensation or Automobile Injury Please ask for an additional form.

I hereby authorize payment directly to Scottsdale Joint Center and Stuart C. Kozinn MD LTD, of all insurance coverage including Medicare for surgery and /or office charges, and I authorize them to release any information necessary to process insurance benefits on my behalf. I also authorize the release of my medical records to any insurance company with whom I have health insurance coverage. In addition, I authorize the release of medical information to my primary care or referring and treating physicians in regard to my management. Initials_____

I understand that Scottsdale Joint Center and Stuart C. Kozinn MD Ltd receives financial payments for ancillary services such as Physical Therapy, Durable Medical Equipment, X-rays, Assistant Surgeon fees and medications such as Hylagan, Supartz, and steroid cortisone injections. I understand that alternative ancillary services, physical therapy, x-rays or medical equipment, can be provided at another outside facility at my request at any time. Initials_____

I understand that doctor and office fees are due and payable when services are rendered. I understand that I am fully responsible for all charges and any balance due after payment by insurance, and that insurance coverage does not necessarily guarantee payment of charges. Initials_____

A copy of your insurance cards(s) and driver's license is required.

I, the undersigned, agree to the terms set forth in the above paragraphs, and authorize treatment by the doctor(s) and physical therapists in this office.

Signature_____ Date_____

I have received and reviewed a copy of the "Notice of the Privacy Practices" from the Scottsdale Joint Center Initials_____