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: ________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

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

Person to contact in case of emergency________________ Phone________________

Email Address________________________

Workmen Compensation Insurance Information

Insurance Company________________ Date injured____________Claim Number____________

Insurance Company Address________________ Telephone Number ________________

Insurance Company Contact- Rehabilitation Nurse______________________________

In your own words what happened? ______________________________

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Auto Injury

Insurance Company________________ Address________________ Claim Number____________

Attorney Name / Address/ Telephone Number______________________________

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In your own words what happened?______________________________

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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____________