SVOS
SUN VALLEY ORTHOPEDIC SURGEONS

Martin G. Sterusky, MD
Robert C. Waldrip, MD
Travis S. Jensen, DPM

OrthoArizona

Joseph M. Janzer, DO
Lawrence J. Kelly, MD

❑ New Patient ❑ Update Only

❑ Sterusky ❑ Waldrip ❑ Jensen ❑ Janzer ❑ Kelly

ALL INFORMATION MUST BE COMPLETED - PLEASE PRINT Today's date: _____

Patient Information

❑ Mr. ❑ Mrs. ❑ Miss ❑Ms. Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Patient's Last Name: _____ First: _____

SS #: _____ Date of Birth _____ Sex:

Street Address: _____

City: _____ State: _____ Zip Code:

e-mail Address: _____

2nd address (out-of-state)
Street Address: _____

City: _____ State: _____ Zip Code:

Home Phone #: _____ Cell Phone #: _____ Work Phone #:

Race:	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Hispanic/Latino	❑ Native Hawaiian or other Pacific Islander ❑ Prefer not to answer ❑ White
Ethnicity (Ethnic Origin):	❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Prefer not to answer	

Primary Language Spoken: _____

Preferred Pharmacy Information

Pharmacy Name: _____

Pharmacy Address/Cross Streets: _____

Pharmacy Phone #: _____ Pharmacy Fax #: _____

Employment Information

Employer: _____ Occupation: _____

Employer Phone #: _____

Street Address: _____

City: _____ State: _____ Zip Code:

Emergency Contact

Emergency Contact Name: _____ Contact Phone # _____

Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Primary Care Physician Information

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Primary Care Physician Name: _____ Phone #: _____

Referring Physician (if didn't than Primary Care): _____ Phone #: _____

Insurance Information

Is your condition related to an accident of any kind? ❑ Yes ❑ No ❑ Work Related ❑ Auto Accident

Date of Injury: _____

If this is a work injury, has medical treatment been authorized by your employer? ❑ Yes ❑ No

Primary Insurance Information

Name: _____

Address _____

_____

Phone #: _____

Policy #: _____

Group #: _____

Policy Holder (if different than patient):

Name: _____

Date of Birth: _____ Sex: ❑ M ❑ F

Relationship to Patient:
❑ Self
❑ Spouse
❑ Child
❑ Other _____

Secondary Insurance Information

Name: _____

Address _____

_____

Phone #: _____

Policy #: _____

Group #: _____

Policy Holder (if different than patient):

Name: _____

Date of Birth:

Relationship to Patient:
❑ Self
❑ Spouse
❑ Child
❑ Other _____

Consent to Receive Medical Information

The person listed below has my consent to receive medical information, concerning the above patient, in person or over the phone. They will also be able to pick up any necessary prescription (other than controlled substances), x-rays and lab results.

Name: _____ Phone #: _____

Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other_____

Authorization to Bill/Pay

I hereby authorize Sun Valley Orthopedic Surgeons to release any information required in the course of my examination or treatment which could include HIV, communicable disease, or drug abuse information. I also hereby authorize payment directly to the business office of Sun Valley Orthopedic Surgeons for the surgical and/or medical benefits, if any, otherwise payable to me for services rendered. *I understand that I am financially responsible for all charges not covered by my insurance. Further, I understand that I am responsible for all charges incurred in the collection of my account(s) and will pay all fees involved should my account be placed with a collection services.*

Printed Name: _____ Phone #: _____

Patient or Guardian Signature: _____ Date: _____