THE DESERT SPORTS MEDICINE AND SHOULDER CLINIC, LLC
Arthoscopic Reconstructive Surgery of the Shoulder and Knee & Sports Medicine

David P. Richards, MD, FRCSC

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY OR THE GUARANTOR MAY BE BILLED DIRECTLY.

TODAY'S DATE: ____________________

FULL LEGAL NAME: ____________________ NICKNAME: ____________________

LEGAL GUARDIAN (if Minor): ____________________ RELATION: ____________________

ADDRESS 1: ____________________ CITY: ____________________ STATE: ____________ ZIP: ____________

ADDRESS 2: ____________________ CITY: ____________________ STATE: ____________ ZIP: ____________

HM PHONE: ____________ WK PHONE: ____________________ CL PHONE: ____________

EMAIL: ____________________ SSI#: ____________________ DOB: ____________

GENDER: ☐ MALE ☐ FEMALE MARRITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMPLOYER: ____________________

REFERRED BY: ____________________

EMERGENCY CONTACT: ____________________

RELATIONSHIP: ____________________ PHONE # WHERE THEY CAN BE REACHED: ____________

PRIVATE HEALTH INFORMATION MAY BE RELEASED TO:

NAME: ____________________ RELATIONSHIP: ____________________ RELEASE: ☐ Y ☐ N

NAME: ____________________ RELATIONSHIP: ____________________ RELEASE: ☐ Y ☐ N

PRIMARY INSURANCE CO: ____________________ PHONE #: ____________

CLAIMS ADDRESS: ____________ CITY: ____________________ STATE: ____________ ZIP: ____________

POLICYHOLDER'S NAME: ____________________ POLICYHOLDER'S DATE OF BIRTH: ____________

POLICYHOLDER'S EMPLOYER: ____________________ PHONE #: ____________

POLICYHOLDER'S SS#: ____________________ ID # ON CARD: ____________

GP/POLICY #: ____________ PATIENT RELATION TO POLICYHOLDER: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

SECONDARY INSURANCE CO: ____________________ PHONE #: ____________

CLAIMS ADDRESS: ____________ CITY: ____________________ STATE: ____________ ZIP: ____________

POLICYHOLDER'S NAME: ____________________ POLICYHOLDER'S DATE OF BIRTH: ____________

POLICYHOLDER'S EMPLOYER: ____________________ PHONE #: ____________

POLICYHOLDER'S SS#: ____________________ ID # ON CARD: ____________

GP/POLICY #: ____________ PATIENT RELATION TO POLICYHOLDER: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

OTHER INSURANCE CO: ____________________ PHONE #: ____________

CLAIMS ADDRESS: ____________ CITY: ____________________ STATE: ____________ ZIP: ____________

POLICYHOLDER'S NAME: ____________________ POLICYHOLDER'S DATE OF BIRTH: ____________

POLICYHOLDER'S EMPLOYER: ____________________ PHONE #: ____________

POLICYHOLDER'S SS#: ____________________ ID # ON CARD: ____________

GP/POLICY #: ____________ PATIENT RELATION TO POLICYHOLDER: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

I hereby authorize The Desert Sports Medicine and Shoulder Clinic, LLC to furnish information to insurance carrier concerning me and/or my dependent's illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or dependent. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account/my dependent's account for any professional services rendered. I understand that I am responsible for any amount not covered by insurance. I understand that nonpayment may result in collection efforts and any collection and/or legal fees incurred as a result of nonpayment is my financial responsibility. I certify that the information on this form is true and correct to the best of my knowledge, and I will notify The Desert Sports Medicine and Shoulder Clinic, LLC of any changes. (A copy of this authorization shall be as valid as the original.)

PATIENT SIGNATURE: ____________________ DATE: ____________

(If patient is a minor, parent or legal guardian must sign.)

FORM No. 012DPR