**Hofmann Arthritis Institute**
**24 South 1100 East Suite 101**
**Salt Lake City, UT 84102**

## PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____ Gender: M F

Mailing Address: _____

City: _____ State: _____ Zip: _____-(_____)

Additional four digits of Zip ALSO

Home Phone: _____ Cell Phone: _____

Social Security Number: _____ Primary Care Physician: _____

Race: _____ Language: _____ E-mail: _____

Marital Status: Married Single Widowed Divorced

Spouse Name: _____ Spouse Date of Birth: _____

Spouse Social Security #: _____

**Are you over the age of 18?** Yes ☐ No ☐

## EMERGENCY CONTACT:

**1** _____ Phone#: _____ Relation: _____

**2** _____ Phone#: _____ Relation: _____

## EMPLOYER INFORMATION:

**Employment Status:** Employed ☐ Unemployed ☐ Retired ☐

Employer Name: _____ Employer Phone#: _____

## INSURANCE INFORMATION:

**Primary Insurance:** _____ ID#: _____ Group #: _____

Policy Holder: _____ Relation to Patient: _____

Policy Holder DOB: _____ SS#: _____ Phone#: _____

**Secondary Insurance:** _____ ID#: _____ Group #: _____

Policy Holder: _____ Relation to Patient: _____

Policy Holder DOB: _____ SS#: _____ Phone#: _____

**Workers Comp** Yes ☐ No ☐ Date of Injury: _____ Claim #: _____

Case Worker Name: _____ Number: _____

**Consent to Treat:** I authorize the physician or physicians in charge of the care of the above named patient to administer anesthetics and/or medications and to perform such operations and/or diagnostic procedures as may be deemed necessary by the physician for the diagnosis and treatment of this patient.

**Financial Responsibility:** I agree to be personally and fully responsible for payment for services rendered in accordance with any insurance benefits where applicable. I understand that I am financially responsible for charges not covered by my plan or for claims denied because of my failure to comply with conditions set by my insurance carrier. These conditions may include but are not limited to: failure to make co-payment or obtain a written referral for services provided by someone other than my primary care physician. A finance charge of 1.5% per month of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an addition 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees court costs.

**Assignment of Benefits:** I request insurance benefits for services provided by paid directly to the medical clinic. I verify the accuracy of the above information and I authorize the release of any medical information necessary to process payment for services provided.

Signature _____ Date _____