SCOTTSDALE HEALTHCARE℠

Piper Outpatient Surgery Center
9007 E. Shea Boulevard
Scottsdale, AZ 85260-6709
Tel: (480) 323-3950

Scheduled Surgery Date _____ Surgeon _____ Referring Physician _____

PATIENT INFORMATION

Legal Name (Last, First, Middle)

Permanent Address

City | State | Zip | Primary Language

Phone (Home) | Social Security Number | Birthdate | Place of Birth

Have you been a patient at any Scottsdale Healthcare Facility? ☐ Yes ☐ No Religious Preference:

Patient is ☐ Male ☐ Female ☐ Child ☐ Adult | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer Name | Occupation

Address

City | State | Zip

Phone (Work) | Employed ☐ Full Time ☐ Part Time | Retired Date

Emergency Notify | **Relation** | **Phone No.**

Are you a year round resident of Arizona? ☐ Yes ☐ No If not, please note your local address below and length of stay in Arizona:

Local Address From to

RELATIVE / SPOUSE INFORMATION

Legal Name (Last, First, Middle) | Relationship to patient

Permanent Address

City | State | Zip

Phone (Home) | Social Security Number | Birthdate

Employer Name

Address

City | State | Zip

Phone (Work) | Occupation | Retired Date

INSURANCE INFORMATION

PRIMARY

Insurance Company

Person Insured | Relationship to patient

Social Security No. of Insured | Policy No. | Group No.

Insurance Address

City | State | Zip

Phone No. | Authorization or Pre-certification required? ☐ Yes ☐ No | Authorization #

SECONDARY

Insurance Company

Person Insured | Relationship to patient

Social Security No. of Insured | Policy No. | Group No.

Insurance Address

City | State | Zip

Phone No. | Authorization or Pre-certification required? ☐ Yes ☐ No | Authorization #

INDUSTRIAL

Industrial Insurance Carrier | Policy No.

Address

City | State | Zip

Employer | Phone No.

Date of injury | Claim No.

INSURANCE CARDS AND INSURANCE CO-PAYMENT REQUIRED UPON REGISTRATION DAY OF SURGERY