Arizona Endocrinology Center
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PLEASE PRINT

Date: ____/____/____ **SSN#**:_____-_____-_____

Patient Name: _____ DOB: ____/____/____ Age: _____
Address:_____City:_____St:____Zp:_____
Home Phone: (___) _____Cell Phone :(___) _____
Work Phone :(___) _____ E-Mail Address: _____
How did you hear about us? ( ) Referring Physician ( ) Advertising ( ) Internet ( ) Friends/ Family
Please Circle: Male/Female
Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed
Ethnic background: Caucasian (___) American Indian (___) African American (___)
Hispanic (___) Asian (___) Other (___)
PatientEmployer:_____Occupation:_____
Emergency Contact:_____Relationship:_____Phone:_____
Name of Spouse:_____DOB:_____Phone:_____
Primary Care Physician:_____Ph:_____Fax:_____
Pharmacy Name:_____Ph:_____Address:_____

INSURANCE INFORMATION

*****DO YOU HAVE MEDICARE? _____ YES _____ NO*****

Primary Insurance: _____ Secondary Insurance: _____
Guarantor's Name: _____ Guarantor's Name: _____
Guarantor's ID # _____ Grp #_____ Guarantor's ID # _____ Grp#:_____
Guarantor's SSN: ___-___-_____ DOB: ___/___/____ Guarantor's SSN: ___-___-____ DOB: ___/___/___

Assignment & Release: I hereby assign my insurance benefits, including Major Medical, to **Arizona Endocrinology Center.** Any overpayment will be refunded to the insured. I am financially responsible for charges which are not paid by the insurance carrier at contracted rate. I hereby authorize **Arizona Endocrinology Center** to release any information acquired in the course of my examination or treatment to my referring physician, any physician involved in my treatment, or to my insurance company. I hereby authorize photocopies of this form to be as valid as the original.

Date:_____Signature:_____