Arizona Endocrinology Center

Phone (602) 439-9000 Fax (602) 978-5233

15640 N. 28th Drive

Phoenix, AZ 85053

Chet Monder, MD.
Richard O. Dolinar, MD.
Radhika Vattikuti, MD.
Hyun-Suk Chong, MD.
Amanda Sherwin, RD.
Anh Nguyen, MD.

Stefan Hasinski, MD.
Carrie A. Phillips, MD.
Meera C. Menon, MD.
Yasmin Akhunji, MD.
Maja Davidson, MD.
Heike Hilker, PA.

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:____

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GENERAL CONSENT TO TREAT

I, with my signature, authorize Arizona Endocrinology Center and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals involved in my care and treatment.

Print name: ____

Signature: ____Date: _________________