ARIZONA ENDOCRINOLOGY CENTER

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PLEASE PRINT

Date: ____/____/____ **SSN#:______-______-_________**

Patient Name:___________________________________ Birthdate: ____/____/____ Age:________________
Address:_____________________________________City:________________ST:__________Zip:__________
Home Phone: (___)_______________Work Phone: (___)______________Cell Phone:(___)_______________

E-Mail Address:__________________________________

Please Circle: Male/Female
Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

Ethnic background:
Caucasian____ Native American_____African American_____Hispanic_____Asian_____Other______

Patient Employer:_____________________________________Occupation:___________________________

In case of emergency notify:__________________Relationship:_______________Phone:_________________
Name of Spouse:_____________________DOB:____________Phone:________________________________

Primary Care Physician:________________________Phone #:________________Fax #:_________________

Pharmacy Name:__________________Address:___________________________Phone #_________________

INSURANCE INFORMATION

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

Primary Insurance Name: _________________________ Secondary Insurance Name: ____________________
Guarantor's Name:______________________________ Guarantor's Name: ____________________________
Guarantor's ID # _______________ Group #_________ Guarantor's ID # _______________ Group #________
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. 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:____