

Arizona Endocrinology Center

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PLEASE PRINT

Date: ___/___/___

SSN#: _____ - _____ - _____

Patient Name: _____ Birthdate: ___/___/___ Age: _____

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: (____) _____ Cell Phone:(____) _____ Work Phone: (____) _____

E-Mail Address: _____

Please Circle: Male/Female

Status: Single Married Divorced Separated Widowed

Ethnic background:

Caucasian(____) American Indian(____) 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: ___/___/___

*Prescription Insurance:

Insurance Name: _____ ID # _____

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: _____