Arizona Endocrinology Center

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PLEASE PRINT

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

Patient Name:_____ DOB: ____/____/____Age:_____
Address:_____City:_____ST:_____Zip:_____
Home Phone: (___)_____Cell Phone:(___)_____Work:(___)_____
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:_____
Emergency Contact:_____Relationship:_____Phone:_____
Name of Spouse:_____DOB:_____Phone:_____
Primary Care Physician:_____Phone #:_____
Pharmacy Name: _____Ph.: _____Address: _____

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 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:_____