



t: 623.773.2828 f: 623.773.0370

CIRCLE: **New Patient**

**Update**

**Patient Registration**

Last Name: \_\_\_\_\_  
 First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Sex: M F Marital Status: S D M W O  
 Responsible Party: (circle) Self Spouse Parent(s)  
 Address: \_\_\_\_\_  
 \_\_\_\_\_ Apt/unit # \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Spouse's name/Parent(s) (if Pt is a minor) \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Home: ( ) - \_\_\_\_\_  
 Work: ( ) - \_\_\_\_\_ x  
 Cell: ( ) - \_\_\_\_\_  
 Pager: ( ) - \_\_\_\_\_  
 Fax: ( ) - \_\_\_\_\_  
 Email: \_\_\_\_\_

Complete this section and provide a copy of your insurance card

**Primary Insurance:**

Insured Last Name: \_\_\_\_\_  
 First Name and MI: \_\_\_\_\_  
 SSN: \_\_\_\_\_  
 Insured ID: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Sex: M F  
 Employment Status: \_\_\_\_\_  
 Insurance Carrier: \_\_\_\_\_  
 Group/Employer Name: \_\_\_\_\_  
 Plan Name: \_\_\_\_\_  
 Group Number: \_\_\_\_\_  
 Account Plan Name: \_\_\_\_\_  
 Effective Date: \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_  
 Rel to Guarantor: \_\_\_\_\_  
 Claims Mailing Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Referred by: \_\_\_\_\_

**Secondary Insurance:**

Insured Last Name: \_\_\_\_\_  
 First Name and MI: \_\_\_\_\_  
 SSN: \_\_\_\_\_  
 Insured ID: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Sex: M F  
 Employment Status: \_\_\_\_\_  
 Insurance Carrier: \_\_\_\_\_  
 Group/Employer Name: \_\_\_\_\_  
 Plan Name: \_\_\_\_\_  
 Group Number: \_\_\_\_\_  
 Account Plan Name: \_\_\_\_\_  
 Effective Date: \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_  
 Rel to Guarantor: \_\_\_\_\_  
 Claims Mailing Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Assignment and release:**

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I authorize the provider to release any information necessary to process this claim. I authorize the office to release all Medical Information Necessary to any hospital, specialist office, and any insurance company acting on my behalf concerning advise, care, treatment, services including drug, alcohol, or mental and nervous treatment unless specifically excluded by me below, for purposes of medical treatment and evaluating and administering claims

Signed:

Date:

|