East Valley Family Medical

PHONE (480) 963-1853 FAX (480) 963-1854

Patient Name: _____D.O.B_____

Address: _____

City: _____State:_____Zip:_____

Cell Phone: _____ Home Phone: _____

Email Address: _____

Preferred Language: _____ Ethnicity: ___ _____

Insurance changes? _____

If Yes then Primary/Secondary or both_____

Policy Holder's Name and DOB _____

Emergency Contact (and Relationship): _____

_____

Preferred Phone Number: _____

Relationship Status: _____ Race:_____

PHARMACY INFO:

Pharmacy: _____

Pharmacy Phone Number: _____

Address/Cross Streets: _____

_____

I hereby give East Valley Family Medical authorization to view my prescription history from external sources.

Patient Signature: _____Date:_____