EAST VALLEY FAMILY MEDICAL Patient Information

Today's Date: _____

Name (first, middle, last): _____Date of Birth: _____ Sex: ___

Ph #: _____ Marital Status: _____ SS # _____ Email: _____

Address: _____ City/Zip: _____

Secondary Contact: _____ Emergency Ph #: _____

Secondary Address : _____ City/Zip: _____

Employer: _____Work Ph #: _____ Cell #: _____

Employer Address: _____City/Zip: _____

Spouse/Parent 's Name: _____Ph #: _____

Responsible Party Information:

Policy Holder's Name (first, middle, last): _____ Date of Birth: _____

Address: _____ City/ Zip: _____

Relationship to Patient: _____SS #: _____ Email: _____Phone: _____

Primary Insurance Information :

Name of Insurance Company: _____ Policy #: _____

Group ID #: _____ ID #: _____ Copay $: _____

Billing Address: _____ City/ Zip: _____

Secondary Insurance Information:

Name of Insurance Company: _____ Policy #: _____

ID #: _____Group ID #: _____ Copay: _____

Do you have an ADVANCE DIRECTIVE/LIVING WILL? Yes☐ No☐ Are you an ORGAN DONOR? Yes☐ No☐

The patient verifies that all information provided is true and correct. The patient has full knowledge that the patient is responsible for all services rendered and that he/she is contractually bound to pay for said services. This includes all costs of collections and a reasonable attorney's fee, if collections become necessary. Patient waives his/her confidentiality rights should collection become necessary. Patient authorizes and requests payments under insurance plans be paid directly to the above provider for any services provided. Patient also authorizes the release of any information requested by his/her insurance carrier to process insurance claims.

Signature: _____ Date: _____