East Valley Family Medical

Today's Date: _____

Name (first, middle, last):

_____ Date of Birth: _____ Sex: ___

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

Address: _____ City/Zip: _____

Emergency Contact: _____ Emergency Ph #: _____

Emergency Address : _____ City/Zip: _____

Pharmacy: _____ Cross streets: _____

Employer: _____ Work Ph #: _____ Cell #: _____

Employer Address: _____ City/Zip: _____

Preferred Language: _____ Ethnicity: __ Hispanic or Latin __ Not Hispanic or Latin __ Decline to Report

Race: _____ Are you a "snowbird"? (Spend part of the year elsewhere?) Yes ___ No___

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__ If not, would you like information on Advance Directives? 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: _____