

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely. If you have questions we'll be glad to help you.

PATIENT INFORMATION

DATE _____ DOCTOR _____ HOME PHONE _____

NAME _____ SSN _____
Last First MI

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SEX M F AGE _____ BIRTHDATE _____ MARITAL STATUS: S M W OTHER

PATIENT EMPLOYED BY _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT:
 NAME _____ WORK# _____ HOME# _____

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR ACCT.# _____
Last First MI

RELATIONSHIP TO PATIENT _____ BIRTHDATE _____ SSN _____

ADDRESS (If different from patient) _____ PHONE _____

CITY _____ STATE _____ ZIP _____

PERSON RESPONSIBLE EMPLOYED BY _____ PHONE _____

SPOUSE NAME _____ EMPLOYED BY _____ PHONE _____

*** PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD/CARDS.**

PRIMARY INSURANCE

SECONDARY INSURANCE

INSURANCE INFORMATION

INS. CO. NAME _____

ADDRESS _____

CITY, ST, ZIP _____

MEMBER'S NAME _____

I.D.# _____

GR. # _____

CO PAY _____

INS. CO. NAME _____

ADDRESS _____

CITY, ST, ZIP _____

MEMBER'S NAME _____

I.D.# _____

GR. # _____

CO PAY _____

AUTHORIZATION

I hereby authorize Gilbert Medical Center to release any information necessary to process insurance claims. I understand that payment will be made directly to Gilbert Medical Center and that I am financially responsible for charges not covered by my insurance company.

Signature **X** _____