



PATIENT REGISTRATION

Office locations in: Chandler • East Mesa • North Scottsdale • Phoenix

PLEASE PRINT

Name: _____ Date of Birth: _____ Male Female

Marital Status S M W D Sep Who is your primary care physician? _____

SS# _____ Home Phone: _____ Work Phone: _____

Address: (Street) _____ Cell Phone: _____

City/State/Zip: _____ Spouse Name: _____

Employer: _____ Spouse Employer: _____

Work Address: _____ Spouse Work Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Name of person responsible for account: _____

Are you a student attending school? Yes No Name of School: _____

Who referred you to us? _____

If patient is a child, or a dependent on parent's health insurance plan, please complete the following information:

Father's Name: _____ Father's Work Phone: _____

Father's Employer: _____ Father's SS #: _____

Father's Work Address: _____

Mother's Name: _____ Mother's Work Phone: _____

Mother's Employer: _____ Mother's SS #: _____

Mother's Work Address: _____

PRIMARY INSURANCE: _____

Policyholder's Name: _____ Relationship to Patient: _____

Policyholder's Birthdate: _____ ID #: _____ Co-Pay Amount \$: _____

SS #: _____ Group #: _____

SECONDARY INSURANCE: _____

Policyholder's Name: _____ Relationship to Patient: _____

Policyholder's Birthdate: _____ ID #: _____ Co-Pay Amount \$: _____

SS #: _____ Group #: _____

Names of other family members living at home: _____

Assignment and Release: 1. I hereby assign my insurance benefits to be paid directly to the physician; or, if my current policy prohibits direct payment to the doctor, I instruct and direct my insurance company to make out the check to me and Arizona Allergy Associates. 2. I also authorize the physician to deposit checks received on the patient's account when made out to the patient. 3. I also authorize the physician to release any information required to process claims or required in the course of my exam and treatment. 4. I hereby agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement. 5. I authorize Arizona Allergy Associates to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature: _____ Date: _____