SONORAN ALLERGY & ASTHMA CENTER, PC

7312 E. Deer Valley Rd., Ste. 100
Scottsdale, AZ 85255

PATIENT RECORD

PATIENT: ______________________________ SEX: M / F DOB: __________
(LAST) (FIRST) (INITIAL)

ADDRESS: ______________________________
(STREET) (CITY) (STATE) (ZIP CODE)

PHONE:
HOME #: ______________________

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOW

WORK #: ______________________

SOCIAL SECURITY #: ______________________

EMERG. #: ______________________

EMPLOYER: ______________________________

OCCUPATION: ______________________________

FAMILY DOCTOR: ______________________ PHONE#: ______________

ADDRESS: ______________________________

REFERRED BY: ______________________ **PHONE#:** ______________

(IF PATIENT IS A MINOR)

RESPONSIBLE PARTY: ______________ SS#: __________ DOB: __________

EMPLOYER: ______________________ WORK#: ______________

INSURANCE INFORMATION

PRIMARY INSURANCE: ______________ ID#: __________ GRP#: __________

POLICY HOLDER'S NAME: ______________ SS#: __________ DOB: __________

EMPLOYER: ______________________ WORK#: ______________

SECONDARY INSURANCE: ______________ ID#: __________ GRP#: __________

POLICY HOLDER'S NAME: ______________ SS#: __________ DOB: __________

EMPLOYER: ______________________ WORK#: ______________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS:
I HEREBY AUTHORIZE SONORAN ALLERGY & ASTHMA CENTER, PC TO RELEASE ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO SONORAN ALLERGY & ASTHMA CENTER, PC FOR MEDICAL CARE RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE: ______________________________ DATE: ______________