ARIZONA OCULAR & FACIAL
Plastic Surgery

PATIENT INFORMATION

NAME: ______________________ **SEX:**_____ **PREFFERED NAME:**________________
DATE OF BIRTH:______________________ **AGE:**_____ **MARITAL STATUS:**________________

ADDRESS:____

CITY, STATE, ZIP:____

SOCIAL SECURITY #: ______________________

HOME PHONE: ______________________ **CELL PHONE:**______________________

PREFERRED METHOD OF CONTACT *(circle one)*: **Home Phone** **Cell Phone** **Other:**______________________

EMAIL: ____

DRIVERS LICENSE #: ______________________ **STATE:**______

Please provide your driver's license to receptionist upon first appointment

EMPLOYEMENT STATUS *(circle one)*: **Full-Time** **Part-Time** **Not Employed** **Disabled** **Retired** **Self**

EMPLOYER:______________________ **EMPLOYER PHONE:**______________________

- **PREFERRED PHARMACY:**____

We are required by federal statute to ask the following questions:

RACE:______________________ ☐ I decline to answer this question
ETHNICITY: ______________________ ☐ I decline to answer this question

INSURANCE INFORMATION

(Please provide your insurance card to the receptionist)

PRIMARY INSURANCE:____
POLICY #:______________________ **GROUP #:**______________________

SUBSCRIBER NAME (if other than patient):______________________ **DATE OF BIRTH:** ______________________

SUBSCRIBER SSN:______________________ **RELATION TO PATIENT:** ______________________

SECONDARY INSURANCE (if applicable):____

POLICY #:______________________ **GROUP #:**______________________

SUBSCRIBER NAME (if other than patient):______________________ **DATE OF BIRTH:**______________________

SUBSCRIBER SSN:______________________ **RELATION TO PATIENT:**______________________

IN CASE OF EMERGENCY

EMERGENCY CONTACT:______________________ **RELATION TO PATIENT:**______________________

HOME PHONE:______________________ **CELL PHONE:**______________________

How did you hear about our practice? ____

The undersigned acknowledges that the above information is true and correct.

Signature:____ **Date:**______________________
(If patient is a minor- signature of parent/guardian)

P: (480) 949-5990 | F: (480) 949-0509