ARIZONA WOMEN'S CARE

OBSTETRICS GYNECOLOGY

9823 North 95th Street, Suite 101 - Scottsdale Arizona 85258

Phone (480) 451-8454 ♦ *Fax* (480) 451-3466

PLEASE PRINT FULL DETAILS - This information will help the doctor serve your health needs more effectively.

PATIENT'S NAME	S	M	D	W	DATE OF BIRTH	AGE	SOCIAL SECURITY #
STREET ADDRESS	CITY / STATE / ZIP CODE						HOME PHONE #
PATIENT'S EMAIL					FAMILY EMAIL		CELL PHONE #

IS IT OK TO CONTACT YOU VIA TEXT? **YES** **NO**
RACE: WHITE AFRICAN AMERICAN ASIAN HISPANIC PACIFIC ISLANDER OTHER:
ETHINICITY :

PATIENT'S EMPLOYER	OCCUPATION (STUDENT)?	LENGTH OF EMPLOYMENT	BUSINESS PHONE #
EMPLOYER'S STREET ADDRESS	CITY / STATE / ZIP CODE		****PATIENT PREFERED NUMBER FOR MESSAGES**
(CIRCLE SPOUSE OR PARENT)			
SPOUSE / PARENT NAME	SPOUSE / PARENT SOCIAL SECURITY #		CELL PHONE #
SPOUSE / PARENT EMPLOYER	EMPLOYER ADDRESS		CITY / STATE / ZIP CODE
BUSINESS PHONE #	SPOUSE / PARENT OCCUPATION		SPOUSE DATE OF BIRTH

Emergency Contact

NAME	RELATIONSHIP	HOME # OR CELL PHONE #
PRIMARY PHYSICIAN:	NAME OF PRACTICE	
PHYSICIAN'S PHONE # :	STREET ADDRESS :	CITY / STATE / ZIP CODE
PHARMACY NAME:	PHARMACY PHONE # :	LOCATION / CROSS STREETS

AUTHORIZATION to release information and assignment of benefits.

I authorize payment of medical benefits to the provider for services rendered in the future, without obtaining my signature on each claim submitted and I will be bound by the signature as though I personally signed the claim. I also authorize the release of any medical information necessary. I understand I am responsible for all charges. If this account should be referred to a collection agency, I will be responsible for any collection and / or legalities. I have read and understand the office policy and procedures.

Responsible Party Signature:		***Date:***	