

Melinda M. Martin, M.D.

907 Ainsworth Drive
Prescott, AZ 86305

7750 E. Florentine Rd, Ste A
Prescott Valley, AZ 86314

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

DOB _____ SSN _____ Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ email _____

Employer Name _____ Employer Phone No. _____

Primary Care Physician _____ Phone No. _____

Emergency Contact Name _____ Phone No. _____

Relationship to Patient _____ DOB _____

INSURANCE INFORMATION

Primary Insurance _____ Name of Cardholder _____

Insurance Address _____ DOB _____ SSN _____

_____ Relationship to Insured _____

Insurance Phone No. _____

Secondary Insurance _____ Name of Cardholder _____

Insurance Address _____ DOB _____ SSN _____

_____ Relationship to Insured _____

Insurance Phone No. _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. My signature below indicates that I have read and understand all of the above as well as completing all questions with current information. **I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF WHETHER OR NOT I AM INSURED.** If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees in addition to the remaining balance.

Patient/Parent or Guardian Signature _____ Date _____