

Arizona Community Physicians

Patient Information

FIRST NAME	MIDDLE	LAST NAME	ADDRESS	CITY	STATE	ZIP
HOME PHONE		CELL PHONE	EMERGENCY PHONE#	EMERGENCY CONTACT NAME / RELATION		
/ /						
DOB	SEX	MARITAL STATUS	PAGER	RACE (optional)		
PRIMARY CARE PHYSICIAN			STUDENT? FT OR PT	PREVIOUS NAME		
EMPLOYER NAME		EMPLOYER ADDRESS		EMPLOYER PHONE		

**Billing Information
(If different than patient)**

FIRST NAME	MI	LAST NAME	ADDRESS	CITY	STATE/ZIP	PHONE
Primary Insurance Information						
INSURANCE NAME		EFFECTIVE DATE	MEDICAL CLAIMS ADDRESS			
GROUP ID#		POLICY ID#	RELATIONSHIP OF PATIENT TO SUBSCRIBER			
SUBSCRIBER NAME (POLICY HOLDER)		SUBSCRIBER ADDRESS (if different than patient)		SUBSCRIBER PHONE (if different than patient)		
/ /						
SUBSCRIBER DATE OF BIRTH	SUBSCRIBER	SEX	SUBSCRIBER SSN#		CO-PAY AMOUNT	
SUBSCRIBER EMPLOYER		EMPLOYER ADDRESS		EMPLOYER PHONE#		

Secondary Insurance Information

INSURANCE NAME		EFFECTIVE DATE	MEDICAL CLAIMS ADDRESS			
GROUP ID#		POLICY ID#	RELATIONSHIP OF PATIENT TO SUBSCRIBER			
SUBSCRIBER NAME (POLICY HOLDER)		SUBSCRIBER ADDRESS (if different than patient)		SUBSCRIBER PHONE (if different than patient)		
/ /						
SUBSCRIBER DATE OF BIRTH	SUBSCRIBER	SEX	SUBSCRIBER SSN#		CO-PAY AMOUNT	
SUBSCRIBER EMPLOYER		EMPLOYER ADDRESS		EMPLOYER PHONE#		

By signing this form, I am consenting to Arizona Community Physicians' use and disclosure of my Protected Health Care Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been provided or offered a copy of Arizona Community Physicians' Privacy Statement. I assign all medical and/or surgical benefits including major medical benefits to Arizona Community Physicians for services rendered. By signing this form I am confirming that the above demographic and insurance information is current and correct. If the information is not correct I understand I will be held responsible for all charges incurred in today's visit.

The effective period of this authorization is from today's date to a future date, when I am no longer a patient of the Arizona Community Physicians, P.C. group or am deceased.

PERSON GIVING CONSENT	RELATIONSHIP IF NOT THE PATIENT	DATE
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