INTERNAL MEDICINE AZ
Geriatric Specialties of AZ

P.C. Patient Registration Form

PATIENT INFORMATION:

Patient Name (Last)_____ First: _____Middle Initial: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: ( )_____ Business: ( )_____ Cell: ( )_____
Date Of Birth _____/_____/_____ Age: _____ Sex: Male Female
Social Security Number: _____--_____--_____ Email: _____
Employer/ Occupation: _____ Employer Phone Number: ( ) _____
Emergency Contact (Name) _____ Relationship to Patient_____
Home phone: ( )_____ Business: : ( )_____ Cell: ( )_____
How did you did you hear about us? _____

RESPONSIBLE PARTY:

Guarantor Name: _____ Relationship to Patient: Insured Spouse Child Other
Street Address:_____ City: _____ State: _____ Zip: _____
Home phone: ( )_____ Business: : ( )_____ Cell: ( )_____
Date Of Birth _____/_____/_____ Age: _____ Sex: Male Female
Social Security Number: _____--_____--_____ Employer: _____
Occupation: _____ Employer Phone Number: ( )_____

INSURANCE INFORMATION: **FILL OUT COMPLETELY EVEN IF WE SCANNED CARD**

Primary Insurance
Insurance Co. Name:_____
Address_____
City, State, Zip:_____
Policy Number:_____
Group Number:_____
Policy Holder Name:_____
Relationship to Patient: Insured Spouse Child Other

Secondary Insurance
Insurance Co. Name:_____
Address_____
City, State, Zip:_____
Policy Number:_____
Group Number:_____
Policy Holder Name:_____
Relationship to Patient: Insured Spouse Child Other

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Geriatrics Specialties of Arizona, P. C., to release any information required in the course of my examination or treatment which could include HIV, communicable disease or drug abuse information.
AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of Geriatric Specialties of Arizona P.C., for the surgical and/ or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for all changes, whether or not my insurance company pays them, and any COPAYS and Deductibles are due at the time of service. Also, a $50.00 return check fee for all returned checks. Failure to pay this portion will result in a collection fee of $25.00. No show fees are $50.00 per missed appointment.

SIGNED (Patient or Parent, if minor) _____ DATE_____/_____/_____

PLEASE FILL OUT COMPLETELY

INCLUDING INSURANCE FOR 2024