SOUTHERN ARIZONA INFECTIOUS DISEASE SPECIALISTS
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# PATIENT REGISTRATION

**Patient Last Name**:_____ **First Name**:_____ **MI**:____

Address:_____ Apt:_____ City:_____ ST:_____ ZIP:_____

Home: (____) ___-_____ Work: (____) ____-_____ Cell: (____) ____-_____

Birthdate:____/____/____ Gender: ☐ Male ☐ Female SSN:____-____-____

Email Info:_____@_____.____ Referring / Primary Care Physician:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown

Student Status: ☐ Not a student ☐ Full-Time Student ☐ Part-time Student

Employment: ☐ Employed ☐ Not Employed ☐ Self-employed ☐ Retired ☐ On Military Active Duty ☐ Unknown

Employer name:_____

## Primary Insurance Information (Please provide card – for copy of front and back)

Indicate patient's relationship to primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Other (POA, Attorney, etc)

POLICY HOLDER'S NAME (If self, write self):_____

Policy Holder's Date of Birth: ____/____/____ Policy Holder's SSN#:____-____-____

Insurance Company Name:_____

Policy Number:_____ Group Number:_____ Copay Amt: $____.____

## Secondary Insurance Information (Please provide card – for copy of front and back)

Indicate patient's relationship to primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Other (POA, Attorney, etc)

POLICY HOLDER'S NAME (If self, write self):_____

Policy Holder's Date of Birth: ____/____/____ Policy Holder's SSN#:____-____-____

Insurance Company Name:_____

Policy Number:_____ Group Number:_____ Copay Amt: $____.____

## Emergency Notification Information: (Person to notify in case of emergency, other than parents)

Name:_____ Relationship to Patient:_____

Address:_____ Home number: (____) ____-_____

City:_____ ST:_____ ZIP:_____ Other Number: (____) ____-_____

## NOTICE:

Please read and sign:
I authorize the release of any of my medical or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of benefits to Southern Arizona Infectious Disease Specialists. I fully understand that if my insurance denies payment for any service defined as "non-covered", I will be responsible for that amount due. In the event this account must be placed with Surety Acceptance Corporation for collection, patient or responsible party agrees to pay all collection costs.

**SIGNATURE:**_____ **DATE:**_____

Patient / Parent or Guardian