East Valley Diabetes & Endocrinology
P: 480-782-9531 F: 480-782-9530
myazdr.com

Patient name (First and Last): ________________________________________ SSN: ___________________
Date of birth: _______/_______/__________ Sex: ___M or ___F Marital Status: ___S ___M ___W ___D
Mailing Address: ________________________________________________________ Apt/Lot: ___________
City: __________________________________________ State: _____ ZIP: _______________
Primary phone: (______)______-___________ Secondary phone: (______)______-___________
Email Address: _________________________________________________________
**Emergency Contact** - Name:______________________ Relation:___________ Phone: (_____)_____-________
**Primary care provider**: _______________________________________ PCP Phone: (_____)_____-__________
How did you hear about us? ___Physician (Name:____________________________) ___Friend ___Website
___Internet search ___Other: ____________________________________
Pharmacy name + location: ________________________________________ Phone: (_____)_____-________
Patient Employer: __________________________________________________________________________

**Primary insurance company:** _________________________ Policy:_______________ Group: _____________
Policy holder/guarantor: ________________________________ Date of Birth: _______/_______/__________
Relation to Patient: _______________________ Policy holder/guarantor's Employer: ____________________
Phone number: (______)______-___________ Policy holder/guarantor's SSN: __________________________
**Secondary insurance company:** _______________________ Policy:_______________ Group: _____________
Policy holder/guarantor: ________________________________ Date of Birth: _______/_______/__________
Relation to Patient: _______________________ Policy holder/guarantor's Employer: ____________________
Phone number: (______)______-___________ Policy holder/guarantor's SSN: __________________________

Who may receive information regarding your Protected Health Information?
Name: _____________________________ Phone: (_____)______-_______ Relation: ____________________
Name: _____________________________ Phone: (_____)______-_______ Relation: ____________________
Name: _____________________________ Phone: (_____)______-_______ Relation: ____________________
Name: _____________________________ Phone: (_____)______-_______ Relation: ____________________

**May we leave messages regarding test results and appointments on your answering machine?___Yes___No**

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

Signature _____________________________________________________ Date: ______/______/_________
___Patient ___Parent/Guardian

IF YOU HAVE TWO INSURANCE COMPANIES, PLEASE PRESENT BOTH CARDS SO THAT WE MAY FILE WITH YOUR SECONDARY CARRIER FOR ANY BENEFITS DUE TO YOU.