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.

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Patient Name: ________________________ Date of Birth: _____/_____/_______ Phone: (_____)_____-___________

Medications (Please list all you're currently taking): ___ Copy of medication list attached

Name:____ Strength:____
Name:____ Strength:____
Name:____ Strength:____
Name:____ Strength:____
Name:____ Strength:____
Name:____ Strength:____
Name:____ Strength:____
Name:____ Strength:____
Name:____ Strength:____
Name:____ Strength:____

Personal medical history:

Allergy:_____________________________________ Reaction:____________________________________
Allergy:_____________________________________ Reaction:____________________________________
Allergy:_____________________________________ Reaction:____________________________________
Allergy:_____________________________________ Reaction:____________________________________
Surgery/Procedure: _______________________________________ Date: ____________________________
Surgery/Procedure: _______________________________________ Date: ____________________________
Surgery/Procedure: _______________________________________ Date: ____________________________
Surgery/Procedure: _______________________________________ Date: ____________________________

Previous medical diagnoses/symptoms (if applicable):

____
____
____
____

Family medical history (Mother/Father/Siblings):

____
____
____
____

Tobacco use? ___Yes ___No

PLEASE TAKE THIS INTO THE ROOM WITH YOU