East Valley Diabetes & Endocrinology Ph: 480-782-9531 Fax: 480-782-9530

Demographics and Insurance

Patient Information

Last name: _____

Previous Last name *if applicable:* _____

First name: _____

Previous First Name *if applicable*: _____

SSN: _____

Date of birth:_____/_____/_____ Sex:___M /___F Marital Status: Married / Single / Widowed / Divorced

Mailing Address:_____Apt / Lot: _____

City:_____ State:_____ Zip:_____

Primary phone: (____)_____-_____ Secondary phone: (_____)_____- _____

Email Address: _____

Pharmacy Name and cross street:_____**PCP:** _____

Emergency Contact: Name:_____DOB_____ **Relation**: _____

Phone: (_____)_____- _____

Who may receive information regarding your Protected Health Information?

Name:_____DOB_____Phone: (____)_____-Relation:_____

Name:_____DOB_____Phone: (____)_____-Relation:_____

Name:_____DOB_____Phone: (____)_____-Relation:_____

Name:_____DOB_____Phone: (____)_____-Relation:_____

Patient employer:_____

Primary insurance company:_____**PolicyID:** _____

Group no:_____

Policy holder/guarantor:_____ **Date of birth**: :_____/_____/_____

Relation to patient:_____ Policyholder/guarantor employer:_____

Secondary insurance company:_____Policy:_____

Group:_____

Policy holder/guarantor:_____ Date of birth:_____/_____/_____

Relation to patient:_____ Policyholder/guarantor employer:_____

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

I have received a copy of the Notice of Privacy Practices 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:** _____