



CHANDLER PRIMARY CARE

5950 S. Cooper Rd, Ste 4, Chandler, AZ 85249

Welcome to our practice

Thank you for choosing our practice.

In order to serve you properly we will need the following information. Please Fill in/type in. All information will be strictly confidential.

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ___/___/___ Social Security No: ___-___-___
(MM/DD/YY)

Sex: Female Male Transgender

Relationship Status: Single Married Divorced Widowed Separated Partner

Race / Ethnicity: _____ Preferred Spoken Language: _____

Address: _____

City: _____ State _____ Zip Code _____

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____ Ext: _____

Email Address: _____

Billing Address (if different from Above Address):

Address: _____

City: _____ State _____ Zip Code _____

May We Call you with medical information like results etc. at: Home Work Cell

May we leave a message with medical information like test results on Voicemail: Home Cell

With a Family Member: No Yes If Yes Name _____

Emergency Contacts: Name: _____

Relationship to Patient: _____

Phone Number: _____

Designate 1 other person, who we may share your medical information with, if applicable:

Name: _____ Phone No _____

Living Will or Advance Directive: Yes No Medical Power of Attorney: Yes No



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Patient Employment: Employed Retired Unemployed Disabled Other

Occupation: _____ **Employer:** _____

Phone Number: _____

Responsible party: Same as Patient or

Name: _____

Address, City, State, Zip Code: _____

Phone Number: _____ Cell Phone: _____

Social Security: ____-____-____ Date of Birth: ____/____/____

Sex: Female Male

Employer: _____

***PLEASE PROVIDE US WITH YOUR INSURANCE CARD AND PHOTO ID SO WE MAY MAKE COPIES. THANK YOU.

Insurance Information (Primary Insurance)

Name: _____

Address (where claims need to be sent to): _____

Phone Number: _____

Subscriber's Name: _____

Subscriber's ID Number: _____

Policy Group/ Group Number: _____

Relationship to Subscriber: Self Spouse Child Partner Other _____

Subscriber's Date of Birth: ____/____/____



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Insurance Information (Secondary Insurance)

Name: _____

Address: _____

Phone Number: _____

Subscriber's Name: _____

Subscriber's ID Number: _____

Policy Group/ Group Number: _____

Relationship to Subscriber: Self Spouse Child Partner Other _____

Subscriber's Date of Birth: ____/____/____

Authorization and Acknowledgment

I/ We hereby state the information is true and correct to the best of my/our knowledge. I/We authorize Chandler Primary Care to release any information acquired in the course of treatment to my insurance company, employer, physicians, institutions, or third party payers, as required for certain claims filed.

My/ Our signature signifies my/ our consent to medical treatment deemed necessary by the physicians and /or the office staff acting under the physician's direction.

I/ We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any service or charges are not covered by insurance carrier or my eligibility cannot be verified at the time service, I am responsible for all charges incurred. I understand that any and all co-pays, coinsurances and outstanding balances are due at the time of service. In case I have not met my deductible, I am responsible for making arrangements for payments to Chandler Primary Care at the time of visit(s).

Signature of Patient/ Parent or Guardian

Date