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:** _____-_____-_____ **Sex:** ☐ **Female** ☐ **Male**
(MM/DD/YY)

Marital 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) or Summer 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 Contact: **Name:** _____

Relationship to Patient: _____ **Phone Number:** _____

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

Name: _____ **Relationship to Patient:** _____

Phone Number: _____

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Primary Insurance holder/Primary Subscriber: ☐ Same as Patient If not, please fill out below:

Name: _____

Address, City, State, Zip Code: _____

Phone Number: _____ Cell Phone: _____

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

Relationship to Subscriber: ☐ Spouse ☐ Child ☐ Partner ☐ Other _____

Sex: ☐ Female ☐ Male

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

Primary Insurance Information: Copay Amount, if any: _____

Insurance Name: _____

Insurance Address: _____

Insurance Phone Number: _____

ID Number: _____ Policy/Group Number: _____

Secondary Insurance Information: (if applicable)

Insurance Name: _____

Insurance Address: _____

Insurance Phone Number: _____ Copay Amount, if any: _____

ID Number: _____ Policy/Group Number: _____

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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**

Acknowledgement of Receipt of HIPAA Privacy Notice

This is to acknowledge that I have reviewed Chandler Primary Care's HIPAA privacy notices and able to get a copy online/hardcopy if I want one.

_____ _____

Signature of Patient/ Parent or Guardian **Date**