PATIENT DEMOGRAPHIC INFORMATION

PATIENT NAME____

STREET ADDRESS____ APT___________

CITY______________________________ STATE______________________ ZIP_______________________

DATE OF BIRTH ________/________/____________ SOCIAL SECURITY NUMBER ___________ - ________ - ____________

HOME PHONE________________________________ CELL PHONE _____________________________________

****May we leave messages on your home and/or cell phone? (Please check your answer)*** ☐ HOME ☐ CELL ☐ NO

EMAIL ADDRESS____

EMPLOYER____ WORK PHONE__________________________

EMERGENCY CONTACT ____ RELATIONSHIP___________________

EMERGENCY CONTACT PHONE NUMBER(S)__________________________ ______________________________

PHARMACY NAME____ LOCATION__________________________

<u>RACE</u> (Please check your answer)

CAUCASION/ WHITE BLACK/ AFRICAN AMERICAN HISPANIC OTHER________________________

<u>ETHNICITY</u> (Please check your answer)

AMERICAN HISPANIC OR LATIN AMERICAN PACIFIC ISLANDER OTHER______________________

PRIMARY INSURANCE____ ID #_____________________________

GROUP #______________________________________ SUBSCRIBERS NAME___________________________

SUBSCRIBERS DATE OF BIRTH_____________________________ SUBSCRIBERS SS #______________________

SECONDARY INSURANCE_______________________________________ ID #_____________________________

GROUP #______________________________________ SUBSCRIBERS NAME___________________________

SUBSCRIBERS DATE OF BIRTH__________________________ SUBSCRIBERS SS #_________________________

GUARANTOR (If other than patient) ____

GUARANTOR DOB______/_____/_________ GUARANTOR SOCIAL SECURITY NUMBER___________-________-___________

WHO REFERRED YOU TO THIS OFFICE? ____

I HEREBY CONSENT TO TREATMENT AND AUTHORIZE ARIZONS OBSTETRICS & GYNECOLOGY TO RELEASE PERTINENT INFORMATION TO MY INSURANCE COMPANY IN AN EFFORT TO RECEIVE PAYMENT FOR MY SERVICES. I AUTHORIZE THESE FUNDS TO BE PAID DIRECTLY TO ARIZONS OBSTETRICS & GYNECOLOGY. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR FURNISHING THE CORRECT INSURANCE INFORMATION AND THAT I AM RESPONSIBLE FOR ANY BALANCE NOT PAID BY INSURANCE AS WELL AS ANY ADDED COST INCURRED DUE TO ANY EFFORT TO COLLECT FOR THESE SERVICES.

____ ______________________________

SIGNATURE DATE

PATIENT ACKNOWLEDGEMENT OF HIPAA

Due to federal regulations called Health Information Portability and Accountability Act (HIPAA),

We are required to provide you with an updated copy of the HIPAA Privacy Notice, as well as get a signature from you that you were given a copy of the notice.

By signing below, I certify that I have been given a copy of the Notice of Privacy Policies and Practices and given a chance to have answered any questions I may have regarding the use and / or dissemination of my medical records by Arizons Obstetrics & Gynecology.

______________________________ ______________________

Patient Signature Date

____

Witness Signature

The providers and/or staff of Arizons Obstetrics and Gynecology have my permission to discuss my appointments, test results, or billing information with the following individuals. I understand that no one whose name is not listed by me will be able to call and inquire about my care.

______________________________	______________________________
NAME	RELATIONSHIP TO PATIENT
______________________________	______________________________
NAME	RELATIONSHIP TO PATIENT

☐ **I do not give permission to discuss any of my HIPAA protected information with anyone other than myself.**

______________________________	______________________________
PATIENT SIGNATURE	DATE