# PARKVIEW INTERNAL MEDICINE

PATIENT REGISTRATION

14869 W. Bell Rd. Bldg. 4 Ste 101
Surprise, AZ 85374
P: (623)544-1700 F: (623)544-7544

## PATIENT INFORMATION

| NAME (Last, First, Middle Initial) | SSN# | BIRTHDATE | GENDER ☐ MALE ☐ FEMALE |
|---|---|---|---|
| ADDRESS | CITY, STATE, ZIP | | |
| PRIMARY PHONE - May we leave a detailed message at this phone? ☐ Yes ☐ No | | EMAIL ADDRESS | |
| EMPLOYER | WORK PHONE NUMBER May we leave a detailed message at this phone? ☐ Yes ☐ No | | |

## GUARANTOR INFORMATION

| NAME (Last, First, Middle Initial) | SSN# | BIRTHDATE | GENDER ☐ MALE ☐ FEMALE |
|---|---|---|---|
| ADDRESS (if different from patient) | CITY, STATE, ZIP | | |
| PRIMARY PHONE - May we leave a detailed message at this phone? ☐ Yes ☐ No | | EMAIL ADDRESS | |
| EMPLOYER | WORK PHONE NUMBER May we leave a detailed message at this phone? ☐ Yes ☐ No | RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ GUARDIAN | |

## PRIMARY INSURANCE

| NAME OF INSURANCE COMPANY | POLICY NUMBER | GROUP NUMBER |
|---|---|---|
| NAME OF POLICY HOLDER | RELATIONSHIP TO PATIENT | |
| POLICY HOLDER DATE OF BIRTH | GENDER ☐ MALE ☐ FEMALE | POLICY HOLDER EMPLOYER |
| COPAY AMOUNT | DEDUCTIBLE AMOUNT | INSURANCE COMPANY PHONE # |

## SECONDARY INSURANCE

| NAME OF INSURANCE COMPANY | POLICY NUMBER | GROUP NUMBER |
|---|---|---|
| NAME OF POLICY HOLDER | RELATIONSHIP TO PATIENT | |
| POLICY HOLDER DATE OF BIRTH | GENDER ☐ MALE ☐ FEMALE | POLICY HOLDER EMPLOYER |
| COPAY AMOUNT | DEDUCTIBLE AMOUNT | INSURANCE COMPANY PHONE # |

## AUTHORIZED INDIVIDUALS (List of individuals authorized to receive medical information and financial information)

| NAME (Last, First, Middle Initial) | RELATIONSHIP | Date of Birth | PRIMARY PHONE |
|---|---|---|---|
| NAME (Last, First, Middle Initial) | RELATIONSHIP | Date of Birth | PRIMARY PHONE |
| NAME (Last, First, Middle Initial) | RELATIONSHIP | Date of Birth | PRIMARY PHONE |

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**PATIENT REGISTRATION**

## PHARMACY INFORMATION

NAME OF PHARMACY

ADDRESS

## MAIL-ORDER PHARMACY INFORMATION

NAME OF PHARMACY

ADDRESS

## OTHER INFORMATION

| PRIMARY LANGUAGE OF PATIENT | ETHNICITY | RACE |
|---|---|---|
| ☐ English | ☐ Hispanic or Latino | ☐ American Indian/Alaska Native/Native Hawaiian |
| ☐ Spanish | ☐ Not Hispanic or Latino | ☐ Asian |
| ☐ Other _____ | ☐ Unreported/Refused to Report | ☐ Other Pacific Islander |
| | | ☐ Black/African American |
| | | ☐ Unreported/Refused to Report |
| | | ☐ More than one Race |
| | | ☐ White (Caucasian) |

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to **PARKVIEW INTERNAL MEDICINE**. I also authorize **PARKVIEW INTERNAL MEDICINE** to release any information required to process my claims. I also understand that any and all changes to the above information must be presented to **PARKVIEW INTERNAL MEDICINE** in writing.

_____ _____
Patient Name (Please print) Date of Birth

_____
Signature of Patient or Parent/Guardian

_____
Printed Name of Parent or Guardian

_____
Date