

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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS		CITY, STATE, ZIP		
PRIMARY PHONE - May we leave a detailed message at this phone? <input type="checkbox"/> Yes <input type="checkbox"/> No		EMAIL ADDRESS		
EMPLOYER		WORK PHONE NUMBER May we leave a detailed message at this phone? <input type="checkbox"/> Yes <input type="checkbox"/> No		

GUARANTOR INFORMATION

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

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY NUMBER	GROUP NUMBER
NAME OF POLICY HOLDER		RELATIONSHIP TO PATIENT	
POLICY HOLDER DATE OF BIRTH	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> 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 <input type="checkbox"/> MALE <input type="checkbox"/> 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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PHARMACY INFORMATION

NAME OF PHARMACY

ADDRESS

MAIL-ORDER PHARMACY INFORMATION

NAME OF PHARMACY

ADDRESS

OTHER INFORMATION

PRIMARY LANGUAGE OF PATIENT

- English
- Spanish
- Other _____

ETHNICITY

- Hispanic or Latino
- Not Hispanic or Latino
- Unreported/Refused to Report

RACE

- American Indian/Alaska Native/Native Hawaiian
- Asian
- 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