CENTRAL MESA MEDICAL
204 N. CENTER ST.
MESA, AZ 85201

# PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. **Please print.** All information will be confidential.

Date _____ Patient Name _____ Patient # _____
(FIRST MI LAST)
SS #/SIN _____ ☐ Male ☐ Female Birthdate _____ Home phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
E-Mail _____ Cell Phone _____
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or parent/guardian's employer _____ Work phone _____
Business address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or parent/guardian's name _____ Employer _____ Work phone _____
If patient is a student, name of school/college _____ City _____ State/Prov. _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____
In case of a medical emergency, if the patient is of school age 15+, it is all right to treat in my absence.

X _____ _____
Parent or guardian signature Date

## Responsible Party

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home phone _____
E-Mail _____ Cell phone _____
Driver's license # _____ Birthdate _____ Financial institution _____
Employer _____ Work phone _____
Is this person currently a patient at our office? ☐ Yes ☐ No

## Insurance Information

Name of insured _____ Relationship to patient _____
Birthdate _____ SS #/SIN _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance company _____ Group # _____ Union or local # _____
Ins. Co. address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Relationship to patient _____
Birthdate _____ SS #/SIN _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance company _____ Group # _____ Union or local # _____
Ins. Co. address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____ _____
Signature of patient or parent/guardian if minor Date