7312 E. Deer Valley Road, Suite 100 • Scottsdale, Arizona 85255
Phone: (480) 454-4185 • Fax: (480) 745 2420

New Patient Registration Form

Last Name: ________________________First Name: _______________________M.I.____

Date of Birth: _____/_____/_____ Sex: M/F Social Security Number: _____/____/_____

Address:

____
(Street) (City/State/Zip)

Preferred Phone: ________________________ Secondary Phone:_______________________

Email Address: ____

Who may receive information regarding your protected health information?

____
(Name) (Relationship to You)

Who do we call for an emergency? ________________________ Phone: ________________

May we leave messages regarding test results and appointments on your phone's voicemail? ___ Yes ___ No

How did you hear about our Practice?____

Primary Care Physician: _______________________________ Phone Number: ____________

Employer Name: ___________________________________ Employer Phone: _______________

Employer Address: ____
(Street) (City/State/Zip)

Pharmacy Name: ____

____
(Address of Cross Streets) (Phone Number)

Where would you like your LABS to be drawn? _______________________________________

____
(Address or Cross Streets) (Fax or Phone Number)

Guarantor Information: (Person Responsible for Payment)

Guarantor Name: ______________________________ Social Security Number: _____-__-______

Relationship to Patient: (Circle one) Self/Spouse/Parent Date of Birth:___/_____/_____

Address: (if different from above)____

Employer Name: _____________________________________ Employer Phone: _______________

Employer Address:

____

(Street) (City/State/Zip)

____

Primary Insurance Information:

Insurance Name: _____________________________________ ID Number: ____________________

Address: ____ Group Number: ____________________

Policy Holder: ____________________________________ Effective Date:_____________________

Policy Holder's Social Security Number: ______-_____-______ Policy Holder's DOB:

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Secondary Insurance Information:

Insurance Name: ______________________________________ ID Number: ___________________

Address: ____ Group Number: ____________________

Policy Holder: ____________________________________ Effective Date: ____________________

Policy Holder's Social Security Number: ______-_____-______ Policy Holder's DOB: _____/____/____

____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Apex Physicians. I acknowledge that I am financial responsible for payment whether or not covered by insurance.

Signature: ____ Date: _____/_____/______