❑ Dr. Berry
❑ Dr. Lipschitz
❑ Dr. Riffer

Central Phoenix Medical Clinic, L.L.C.

PERSONAL INFORMATION

NAME ____________ (LAST) ____________ (FIRST) ______ (MI)

HOME PHONE ____________

CELL PHONE ____________

STREET ____________ Apt. # ______

WORK PHONE ____________ EXT ______

CITY ____________ STATE ____________ ZIP ____________

DATE OF BIRTH ____________

EMPLOYED ❑ RETIRED ❑ PART TIME STUDENT ❑ FULL TIME STUDENT ❑

SEX ____________ MARITAL STATUS ____________

EMPLOYER ____________ SCHOOL ____________

SOCIAL SECURITY NO. ____________

E-MAIL ____________

INSURED (card holder) / RESPONSIBLE PARTY (if not patient)

NAME ____________

RELATIONSHIP TO PATIENT ____________

ADDRESS ____________

DATE OF BIRTH ____________

CITY ____________ STATE ____________ ZIP ____________

SOCIAL SECURITY NO. ____________

EMPLOYER ____________

HOME PHONE ____________

POSITION ____________

WORK PHONE ____________

INSURANCE INFORMATION

PRIMARY

INSURANCE COMPANY NAME ____________

ADDRESS ____________

____

ID # ____________ GROUP # ____________

NAME OF INSURED ____________

BIRTHDATE OF INSURED ____________

SECONDARY

INSURANCE COMPANY NAME ____________

ADDRESS ____________

____

ID # ____________ GROUP # ____________

NAME OF INSURED ____________

BIRTHDATE OF INSURED ____________

ADDITIONAL INFORMATION

ARE YOU MEDICARE ELIGIBLE? ❑ YES ❑ NO

DID YOU SUSTAIN AN INJURY WHILE AT WORK? ❑ YES ❑ NO

ARE YOUR INJURIES ACCIDENT RELATED? ❑ YES ❑ NO

ARE YOU CURRENTLY EMPLOYED? ❑ YES ❑ NO

ARE YOU COVERED UNDER AN EMPLOYER OR UNION HEALTH PLAN ? ❑ YES ❑ NO

IS YOUR SPOUSE OR OTHER FAMILY MEMBER CURRENTLY EMPLOYED? ❑ YES ❑ NO

SPOUSE INFORMATION

NAME ____________

DATE OF BIRTH ____________

SOCIAL SECURITY NO. ____________

WORK PHONE ____________

EMERGENCY CONTACT (not living with you)

NAME ____________

RELATIONSHIP TO PATIENT ____________

HOME PHONE ____________

WORK PHONE ____________

ALL COPAYMENTS, COINSURANCE AND DEDUCTIBLES ARE DUE AT THE TIME SERVICE IS RENDERED.
IN THE EVENT THAT PAYMENT IS NOT MADE ON THIS ACCOUNT AND IT IS PLACED WITH A LICENSED COLLECTION AGENCY, I/WE AGREE TO PAY THE FEES OF THE COLLECTION AGENCY EQUAL TO A MAXIMUM OF 50% OF OUR OUTSTANDING BALANCE AT THE TIME THE ACCOUNT IS PLACED WITH THE COLLECTION AGENCY. INTEREST OF 10% PER YEAR WILL BE ACCRUED ON THE PRINCIPAL BALANCE. SHOULD LEGAL ACTION ALSO BE NECESSARY TO COLLECT THE ACCOUNT, I/WE AGREE TO PAY ATTORNEY FEES AND COURT COSTS INCURRED FOR COLLECTION.

CONSENT GIVEN FOR MEDICATION HISTORY DOWNLOAD TO MY CHART FROM THE PHARMACY. ❑ YES ❑ NO

RESPONSIBLE PARTY SIGNATURE ____________ DATE ____________

OUR FINANCIAL POLICY IS PAYMENT AT THE TIME OF SERVICE. I WILL BE PAYING TODAY BY: CASH______ CREDIT CARD______