

**Arizona Community Physicians**

**Patient Information**

FIRST NAME	MIDDLE	LAST NAME	ADDRESS	CITY	STATE	ZIP
HOME PHONE		CELL PHONE	EMERGENCY PHONE#	EMERGENCY CONTACT NAME / RELATION		
DOB	SEX	MARITAL STATUS	EMAIL	RACE (optional)		
PRIMARY CARE PHYSICIAN		STUDENT? FT OR PT	PREVIOUS NAME			
EMPLOYER NAME	EMPLOYER ADDRESS		EMPLOYER PHONE			

**Billing Information  
(If different than patient)**

FIRST NAME	MI	LAST NAME	ADDRESS	CITY	STATE/ZIP	PHONE
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**Primary Insurance Information**

INSURANCE NAME	EFFECTIVE DATE	MEDICAL CLAIMS ADDRESS			
GROUP ID#	POLICY ID#	SELF	SPOUSE	CHILD	OTHER
SUBSCRIBER NAME (POLICY HOLDER)		SUBSCRIBER ADDRESS (if different than patient)		SUBSCRIBER PHONE (if different than patient)	
RELATIONSHIP OF PATIENT TO SUBSCRIBER					
SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SEX	SUBSCRIBER SSN#	CO-PAY AMOUNT		
SUBSCRIBER EMPLOYER	EMPLOYER ADDRESS		EMPLOYER PHONE#		

**Secondary Insurance Information**

INSURANCE NAME	EFFECTIVE DATE	MEDICAL CLAIMS ADDRESS			
GROUP ID#	POLICY ID#	SELF	SPOUSE	CHILD	OTHER
SUBSCRIBER NAME (POLICY HOLDER)		SUBSCRIBER ADDRESS (if different than patient)		SUBSCRIBER PHONE (if different than patient)	
RELATIONSHIP OF PATIENT TO SUBSCRIBER					
SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SEX	SUBSCRIBER SSN#	CO-PAY AMOUNT		
SUBSCRIBER EMPLOYER	EMPLOYER ADDRESS		EMPLOYER PHONE#		

By signing this form, I am consenting to Arizona Community Physicians' use and disclosure of my Protected Health Care Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been provided or offered a copy of Arizona Community Physicians' Privacy Statement. I assign all medical and/or surgical benefits including major medical benefits to Arizona Community Physicians for services rendered. By signing this form I am confirming that the above demographic and insurance information is current and correct. If the information is not correct I understand I will be held responsible for all charges incurred in today's visit.

*The effective period of this authorization is from today's date to a future date, when I am no longer a patient of the Arizona Community Physicians, P.C. group or am deceased.*

PERSON GIVING CONSENT	RELATIONSHIP IF NOT THE PATIENT	DATE
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