

Doctor: Dr. Jyoti Patel

Patient Profile

PATIENT INFORMATION

Name _____
Primary Address _____
City _____ State _____ Zip _____
Phone _____ Alt. Phone _____
E-Mail _____
Secondary Address _____
City _____ State _____ Zip _____

Sex: []M []F
Date of Birth: _____ Age: _____
Driver's License #: _____
Social Security #: _____
Marital Status: []Married []Single []Divorced
Referring Physician: _____
Primary Physician: _____

PATIENT EMPLOYMENT INFORMATION

[]Employed []Retired []Unemployed []Other
Employer's Name: _____
Employer's Phone: _____
Occupation: _____

EMERGENCY CONTACTS

Name	Relationship	Phone
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OK to share my medical information with above person.

RESPONSIBLE PARTY (If patient is under 18 years of age)

Name: _____
Address: _____
City, State, Zip: _____

Employer: _____
Home Phone: _____
Work Phone: _____
SSN: _____
Date of Birth: _____

PRIMARY INSURANCE

Insurance Company Name: _____
ID #: _____
Group/Policy #: _____
Subscriber's Name: _____
Subscriber's Phone #: _____
Relationship to Patient: _____
Subscriber's Employer: _____
Subscriber's SS #: _____
Subscriber's Date of Birth: _____

SECONDARY INSURANCE

Insurance Company Name: _____
ID #: _____
Group/Policy #: _____
Subscriber's Name: _____
Subscriber's Phone #: _____
Relationship to Patient: _____
Subscriber's Employer: _____
Subscriber's SS #: _____
Subscriber's Date of Birth: _____

HIPPA AGREEMENT

Fountain Hills Pediatrics and Internal Medicine staff and business associates will share information as needed to aid in continuing medical care for patients. Information is not sold or given to anyone other than physicians for referrals and billing. We also share information with SMIL, Lab Corp and Sonora Quest. I have received a copy of Fountain Hills Pediatrics & Internal Medicine Privacy Practices as required by HIPPA.

PATIENT/GUARDIAN SIGNATURE

DATE

INSURANCE AUTHORIZATION AND ASSIGNMENT

(Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.***

PATIENT/GUARDIAN SIGNATURE

DATE