TUCSON FAMILY MEDICINE PATIENT INFORMATION FORM

MRN_______________

FIRST NAME MIDDLE LAST NAME | ADDRESS CITY STATE ZIP

HOME PHONE | CELL PHONE | EMERGENCY PHONE # | EMERGENCY CONTACT NAME/RELATION

Date of Birth | Sex | Marital Status | Pager | Race (Optional)

PRIMARY CARE PHYSICIAN | STUDENT? FT OR PT | PREVIOUS NAME(S)

EMPLOYER NAME | EMPLOYER ADDRESS | EMPLOYER PHONE #

Billing Information (If different than Patient)

FIRST NAME MIDDLE LAST NAME | ADDRESS CITY STATE ZIP

Primary Insurance Information

INSURANCE NAME | EFFECTIVE DATE | MEDICAL CLAIMS ADDRESS

GROUP I.D. # | POLICY I.D. # | SELF SPOUSE CHILD OTHER
RELATIONSHIP OF PATIENT TO SUBSCRIBER

SUBSCRIBER NAME (POLICY HOLDER) | SUBSCRIBER ADDRESS (if different than patient) | SUBSCRIBER PHONE (if different than patient)

SUBSCRIBER DATE OF BIRTH | SUBSCRIBER SEX | SUBSCRIBER SSN # | CO-PAY AMOUNT

SUBSCRIBER EMPLOYER | SUBSCRIBER SEX | EMPLOYER PHONE #

Secondary Insurance Information

INSURANCE NAME | EFFECTIVE DATE | MEDICAL CLAIMS ADDRESS

GROUP I.D. # | POLICY I.D. # | SELF SPOUSE CHILD OTHER
RELATIONSHIP OF PATIENT TO SUBSCRIBER

SUBSCRIBER NAME (POLICY HOLDER) | SUBSCRIBER ADDRESS (if different than patient) | SUBSCRIBER PHONE (if different than patient)

SUBSCRIBER DATE OF BIRTH | SUBSCRIBER SEX | SUBSCRIBER SSN # | CO-PAY AMOUNT

SUBSCRIBER EMPLOYER | SUBSCRIBER SEX | EMPLOYER PHONE #

I consent Arizona Community Physicians (ACP) to use and disclose my protected health information for psychiatric care, substance abuse, and HIV/AIDS for carrying out treatment, payment and healthcare operations. ACP has offered me a copy of their privacy policies.
I assign all medical/surgical benefits to ACP for services rendered. I confirm all demographic and insurance information is current and correct. If not, I understand I will be responsible for all charges incurred today.
Effective Sept. 1, 2009 personal balances over sixty (60) days will be assessed a 1% per month finance charge. Balances written off to bad debt or to a collection agency will be assessed a one-time 30% finance charge.

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