CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.

☐ Annual Update
☐ Change Of Information

NAME ______________________________ **DATE OF BIRTH** ______________
Please print your First Name Middle Initial Last Name

STREET ADDRESS ______________________________ **APARTMENT/UNIT #** ______________

CITY ______________________ **STATE** __________ **ZIP CODE** ______________

CELL PHONE ______________________ **HOME PHONE** ______________________
May we leave a message? ☐ Yes ☐ No May we leave a message? ☐ Yes ☐ No

EMAIL ADDRESS Please print clearly ______________________________

PRIMARY CARE PHYSICIAN First and Last Name ______________________________

EMERGENCY CONTACT ______________ **PHONE** ______________ **RELATIONSHIP** ______________

☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled ☐ Child | ☐ Single ☐ Married ☐ Divorced ☐ Life Partner ☐ Widowed

IS PATIENT A MINOR ☐ No ☐ Yes If yes, your First and Last name ______________________

YOUR RELATIONSHIP TO MINOR ☐ Mother ☐ Father ☐ Guardian ☐ Other ______________

PHARMACY ______________________ **CROSSROADS** __________/__________

MAIL-ORDER ______________________ **PHONE** ______________________

DISCLOSURE OF YOUR HEALTH CARE INFORMATION - Please select one:

☐ **I do NOT** grant Central Arizona Medical Associates permission to speak to anyone. I understand the representatives of Central Arizona Medical Associates will not speak to anyone on my behalf.

☐ **I grant** Central Arizona Medical Associates permission to discuss Health Care Information, Treatment Plans and Financial Billing with the individual(s) listed below.

Name	Relationship	Phone Number

☐ Check here if you do not have medical insurance

PRIMARY INSURANCE ______________________
ID # ______________________
GROUP # ______________________
POLICY HOLDER NAME ______________________
POLICY HOLDER DATE OF BIRTH ______/______/______
RELATIONSHIP ☐ Spouse ☐ Parent ☐ Guardian ☐ Other______

☐ Check here if you do not have secondary insurance

SECONDARY INSURANCE ______________________
ID # ______________________
GROUP # ______________________
POLICY HOLDER NAME ______________________
POLICY HOLDER DATE OF BIRTH ______/______/______
RELATIONSHIP ☐ Spouse ☐ Parent ☐ Guardian ☐ Other______

INSURANCE AUTHORIZATION: I hereby authorize Central Arizona Medical Associates to furnish information to insurance carriers regarding my illness and treatments and also assign to the medical providers payments for medical services for myself or dependents. I understand that I am responsible for any copayments, coinsurance and deductibles.

NO–SHOW/LATE CANCELLATION POLICY: I understand that in the event I am unable to keep my scheduled appointment, I must give 24 hours notice and that failure to do so will result in a $35.00 fee.

______________________________ ______________________
PATIENT, PARENT, OR GUARDIAN SIGNATURE **DATE**