Northern Apache County Special Health Care District

PATIENT INFORMATION

Patient's Name	Sex	Date of Birth	Social Security #	Email Address
	M F	/ /	- -	@

Mailing Address ☐ Perm. ☐ Temp.	City & State	Zip Code	Home Phone #
			( ) -

Street Address ☐ Perm. ☐ Temp .	City & State	Zip Code	Cell Phone #
			( ) -

Employer Address	City & State	Zip Code	Business #
			( ) -

How long employed?	Race/Tribe	Census #	Place of Birth	Occupational/Student
		-		

Spouse's Name	Spouse Employer	Date of Birth	Social Security#
		/ /	- -

IF THE PATIENT IS A MINOR OR STUDENT

Mother's Maiden Name	Address	City & State	Zip Code	Home Phone #
				( ) -

Mother's Employer	Address	City & State	Zip Code	Work Phone #
				( ) -

Father's Name	Address	City & State	Zip Code	Home Phone #
				( ) -

Father's Employer	Address	City & State	Zip Code	Work Phone #
				( ) -

INSURANCE INFORMATION (Person Responsible for Payment, If not above)

Address	City & State	Zip Code	Home Phone #
			( ) -

1st Ins: Company Name & Address	Policy #	Group #

Name of Policyholder	Policy Holder's SS#	Policy Holder's DOB
	- -	/ /

2nd Ins: Company Name & Address	Policy #	Group #

Name of Policyholder	Policy Holder's SS#	Policy Holder's DOB
	- -	/ /

EMERGENCY CONTACT

Name	Relationship	Home Number	Cell Number
		( ) -	( ) -

In order to control our cost of billing, we request that office visits be paid at the time service is rendered. We would rather control our billing costs that be forced to raise our fees.

AUTHORIZATION: I hereby authorize the physician(s) to furnish information to insurance carriers concerning any illness/accident, and I hereby irrevocably assign to the doctor all payment for medical services rendered. I understand that I am financially responsible for all the charges whether or not covered by insurance.

_______________________________ Responsible Party Signature

_______________ Date

SMC.SC.100.01