Desert Sky
Women's Healthcare

Patient Forms
New Patient Packet

Patient Information

First Name	Last Name	MI	Preferred Name

Date of Birth: ____________________

Race (circle): American Indian Asian Black/African American Pacific Islander White Decline

Ethnicity (circle): Hispanic/Latino Non-Hispanic/Latino Decline Other: ____________________

Language: ____________________ SS Number: ____________________

Address: ____________________ Marital Status: ____________________

City, State, Zip: ____________________ Occupation: ____________________

Employer: ____________________ Employer Phone: ____________________

Home Phone: ☐ ____________________ (check box if okay to leave message) Cell Phone: ☐ ____________________ (check box if okay to leave message)

Email: ☐ ____________________ (check box if okay to send information)

Emergency Contact

Name: ____________________ Relationship: ____________________

Address: ____________________ Home Phone: ____________________

City, State, Zip: ____________________ Work Phone: ____________________

Cell Phone: ____________________

Insurance Information (Primary)

Ins Company: ____________________ Effective Date: ____________________

Cardholder: ____________________ Cardholder DOB: ____________________

Address: ____________________

City, State, Zip: ____________________

Phone: ____________________

Policy #: ____________________ Group #: ____________________

Copay Amount: ____________________ Deductible: ____________________

Insurance Information (Secondary)

Ins Company:	______________________	Effective Date:	______________________
Cardholder:	______________________	Cardholder DOB:	______________________
Address:	______________________		
City, State, Zip:	______________________		
Phone:	______________________		
Policy #:	______________________	Group #:	______________________
Copay Amount:	______________________	Deductible:	______________________

Referring Provider: ____________________

Primary Care Provider: ____________________ Date Last Seen: ______________________

I certify that the enclosed information is true, to the best of my knowledge. I authorize Desert Sky Women's Healthcare to submit my medical claims directly to my insurance company and to release any information acquired in the course of the examination in order to receive payment for such examination or treatment. I also authorize Desert Sky Women's Healthcare to initiate a complaint to the insurance commissioner on my behalf. I understand that regardless of insurance status, I am ultimately responsible for the balance of my account for all services rendered.

______________________________ Signature   ______________________ Date

______________________________ Witness   ______________________ Date