DESERT ROSE MEDICAL CONSULTANTS, PC
PATIENT INFORMATION

PLEASE COMPLETE THE FOLLOWING INFORMATION ACCURATELY OTHERWISE YOU WILL BE BILLED

PERSONAL INFORMATION

LAST NAME:	FIRST NAME: MIDDLE INITIAL:
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:
STREET ADDRESS:	
CITY: STATE :	ZIP CODE:
HOME PHONE:	WORK PHONE:
CELL PHONE :	MARITAL STATUS:
EMERGENCY CONTACT:	PHONE #:

INSURANCE INFORMATION

PRIMARY INSURANCE: HMO / PPO	SECONDARY INSURANCE: HMO / PPO
Name Of Insurance:	Name Of Insurance:
Name of Insured:	Name of Insured:
Member #:	Member #:
Group #:	Group #:

PLEASE PROVIDE US WITH ALL YOUR INSURANCE CARDS & DRIVER LICENSE/OTHER FORM OF IDENTIFICATION

GUARANTOR/PARENT/INSURED INFORMATION : (If different from patient above)

Name:	SSN: DOB:
Address:	Relationship to patient:
Phone#:	Employer Name:

ARE YOU EMPLOYED? Yes No If employed, then provide:

Employer:	Phone No.:
Address:	

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance and any other health plan to Desert Rose Medical Consultants, PC

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I understand that I am financially responsible for all the charges including, but not limited to co-payments and annual deductibles. I hereby authorize said assignee to release all information to secure the payment.

*Signed:*____*Date:*____________________

Parent or Guardian (If Minor)