PATIENT INFORMATION

Paradise Valley Medical Clinic
Douglas M. Lakin MD

9977 N 90th Street, Suite 180 **PLEASE COMPLETE ONLINE OR PRINT LEGIBLY** Date: _____
Scottsdale, AZ 85258 Phone: 480.614.5800 SSN: _____

First Name: _____ Middle: _____ Last: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____ Spouse: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Phone (Home): _____ Work: _____ Mobile: _____

Current Employment Status: _____ Email Address: _____

Employer: _____ Address: _____ City: _____ ST: _____ Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Pharmacy Name: _____ Phone: _____

INSURANCE INFORMATION

We will need your current insurance card and driver's license. Please give to our receptionist to make copies

Are you on Medicare Insurance: Y _____ N _____ ****This office is committed to regular Medicare & supplementary insurances, not advantage or replacement Medicare plans.**

PRIMARY INSURANCE:

Name: _____ Billing Address: _____

Member ID#: _____ Group#: _____

Subscriber's Name: _____ Date of Birth: _____ Relationship: _____

SECONDARY INSURANCE:

Name: _____ Billing Address: _____

Member ID#: _____ Group#: _____

Subscriber's Name: _____ Date of Birth: _____ Relationship: _____

By signing this form, I authorize payment of medical benefits to Paradise Valley Medical Clinic for my healthcare charges. I also understand and agree I am responsible for the payment of all office fees and uncovered/denied medical charges incurred on behalf of a family member or myself.

Signature: _____ Relationship: _____

****Please bring completed form with you to your office visit with Dr Lakin. Thank you!**