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!**