Sonoran Endocrinology

Phone (623)745-2797 Fax (833) 468-4970
18301 N 79th Ave Suite C 130
Glendale, AZ 85308

Rohit Dwivedi, M.D.

PLEASE PRINT

Date: ____/____/____ **SSN#:_____-_____-_____**

Patient Name:_____ DOB: ____/____/____Age:_____
Address:_____City:_____ST:_____Zip:_____
Home Phone: (___)_____Cell Phone:(___)_____Work:(___)_____
E-Mail Address:_____
Please Circle: Male / Female
Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed
Ethnic background: Caucasian(___) American Indian(___) African American(___)
Hispanic(___) Asian(___) Other(___)
Patient Employer:_____Occupation:_____
Emergency Contact:_____Relationship:_____Phone:_____
Name of Spouse:_____DOB:_____Phone:_____
Primary Care Physician:_____Phone #:_____
Pharmacy Name: _____Ph.: _____Address: _____

INSURANCE INFORMATION
*****DO YOU HAVE MEDICARE? _____ YES _____ NO*****

Primary Insurance Name: _____Secondary Insurance Name:_____
Guarantor's Name:_____ Guarantor's Name:_____
Guarantor's ID # _____Group #_____Guarantor's ID # _____Group #_____
Guarantor's SSN:___/___/_____DOB:___/___/____ Guarantor's SSN: ___/___/____DOB:___/___/___

Assignment & Release: I hereby assign my insurance benefits, including Major Medical, to **Sonoran Endocrinology.** Any overpayment will be refunded to the insured. I am financially responsible for charges which are not paid by the insurance carrier at contracted rate. I hereby authorize Sonoran Endocrinology to release any information acquired in the course of my examination or treatment to my referring physician, any physician involved in my treatment, or to my insurance company. I hereby authorize photocopies of this form to be as valid as the original.

Date:_____Signature:_____