| G & K Medical Associates 10450 W. McDowell Road, Suite 101 Avondale, AZ 85392 (623)935-1000 | 1 |
|--|---|
|--|---|

| (623)935-1000 | PATIENT INFORMATION | | Appt date | |
|---------------------|-----------------------|--------------------------|------------------------|--|
| Account # | | | Marital Status Age | |
| | | Gender Identity | | |
| | | Sexual Orientation | | |
| | | Home Phone | | |
| | | Mobile Phone | | |
| Address | | — · · · · · | | |
| City, ST Zip | | Preferred Contact Metho | d | |
| Work Phone | | | | |
| | RESPO | ONSIBLE PARTY | | |
| Account # | | Patient Relation to Guaß | | |
| Last Name | | Gender | Marital Stat <u>us</u> | |
| First Name | Initial | Date of Birth | Age | |
| Address | | Social Security# | | |
| City, State | | Home Phone | | |
| Employer | | Work Phone | | |
| Address | | | | |
| City, ST | | | | |
| | | NCE INFORMATION | | |
| Primary Insurance | | Policy Holder/Subscriber | | |
| | | Insured Policy ID | | |
| City, ST Zip | | Group # | | |
| Telephone | | Date of Birth | | |
| Effective Dates | | | | |
| | | Copay Amount | | |
| Second Insurance | | Policy Holder/Subscriber | | |
| A 1 1 | | | | |
| City, ST Zip | | Group # | | |
| - 1 | | | | |
| Effective Dates | | | / Holder | |
| | | • | | |
| | EMERGENCY (| CONTACT INFORMATION | | |
| Name | | | | |
| Relation to Patient | | –. | | |
| | Mobile Phone or Pager | | | |
| | | 3 | | |

AUTHORIZE TO RELEASE INFORMATION AND ASSIGNMENT OF MEDICAL BENEFITS

I authorize payments of medical benefits to G & K Medical Associates, P.C. for any medical rendered, or to be obtaining my signature on each claim submitted and the signature will bind me as though I personally signed release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. I a collection agency, I will be responsible for any collection and/or legal fees. I acknowledge receipt of G & K N Notice of Privacy Practices.

Signature Date