

- NEW PATIENT
- NEW OB
- NAME CHANGE
- ADDRESS CHANGE
- INS. CHANGE
- UPDATE

- Phoenix Office
- Scottsdale Office

- Mary Ellen Shannon, M.D.
- Valerie Scholten, M.D.
- Kerry Schlecht, M.D.
- Gracie Lyons, M.D.
- Diane Hlavacek, M.D.
- Misti Bartell, D.O.

Most insurance carriers require us to submit claims for patient services. For this reason, we request all patients to fill out completely and sign the registration form on an annual basis. If you are mailing this form please return ALL copies. THANK YOU

PRESS FIRMLY – 2 PART FORM

PATIENT INFORMATION

Patient's Legal Name _____ Birth Date _____ S.S. # _____
Last First Middle

Address _____ Home Phone # (____) _____ Marital Status _____
Street City Zip Area Code

Employer's Name _____ Occupation (Indicate if Student) _____

Employer's Address _____ Business Phone # (____) _____
Street City/St Zip Area Code

Patient's Primary Doctor _____ Drs. Phone # (____) _____
Name Street City/St Zip Area Code

Name, Address of Nearest Friend or Relative _____ Phone (____) _____ Relationship _____
Area Code

PARENT / SPOUSE INFORMATION

Parent / Spouse Name _____ Birth Date _____ SS# _____
Last First Middle

Address _____ Home Phone _____ Business Phone _____
Street City Zip

Employer _____ Employer's Address _____

PRESS FIRMLY – 2 PART FORM

PRIMARY INSURANCE

Ins. Company Name _____ Address _____ Phone # _____

ID#/Policy # _____ Group # _____ Effective Date _____

Policy Holder's Name _____ Relationship to PT. _____ Birthdate _____

Policy Holder's Address _____ Home Phone _____

Policy Holder's Employer _____ Business Phone _____

SECONDARY INSURANCE

Other Insurance Co. _____ Address _____ Phone _____

Other Insured (If other than patient) _____ Address _____ Phone _____

Birth Date _____ Relationship to Patient _____ ID #/Policy # _____ Group # _____

Other Insured's Employer _____ Address _____ Phone # _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted and I will be bound by the signature as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

Responsible Party Signature

Date