Desert Sky
Women's Healthcare

Patient Forms
New Patient Packet

Patient Information (check box if okay to leave a message)

First Name	Last Name	MI	Preferred Name

Date of Birth: _____

Race (circle): American Indian Asian Black/African American Pacific Islander White Decline

Ethnicity (circle): Hispanic/Latino Non-Hispanic/Latino Decline Other: _____

Language: _____ SS Number: _____

Address: _____ Marital Status: _____

City, State, Zip: _____ Occupation: _____

Employer: _____ Employer Phone: _____

Home Phone: ☐_____ Cell Phone: ☐_____

Email: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Work Phone: _____

Cell Phone: _____

Insurance Information (Primary)

Ins Company: _____ Effective Date: _____

Cardholder: _____ Cardholder DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____

Policy #: _____ Group #: _____

Copay Amount: _____ Deductible: _____

Insurance Information (Secondary)

Ins Company:	_____	Effective Date:	_____
Cardholder:	_____	Cardholder DOB:	_____
Address:	_____		
City, State, Zip:	_____		
Phone:	_____		
Policy #:	_____	Group #:	_____
Copay Amount:	_____	Deductible:	_____

Referring Provider: _____

Primary Care Provider: _____ Date Last Seen: _____

I certify that the enclosed information is true, to the best of my knowledge. I authorize Desert Sky Women's Healthcare to submit my medical claims directly to my insurance company and to release any information acquired in the course of the examination in order to receive payment for such examination or treatment. I also authorize Desert Sky Women's Healthcare to initiate a complaint to the insurance commissioner on my behalf. I understand that regardless of insurance status, I am ultimately responsible for the balance of my account for all services rendered.

_____ _____
Signature Date

_____ _____
Witness Date