East Scottsdale Medical Care

Tracey Drummond, M.D. Jeffrey Baird, M.D.

PATIENT INFORMATION		
Patient Name:	Gender:	DOB:
	SSN:	
Patient Name:	Gender:	DOB:
	SSN:	
Patient Name:	Gender:	DOB:
	SSN:	
Patient Name:	Gender:	DOB:
	SSN:	
Address:	Home Phone:	
	Work Phone:	
City, State, Zip:	Cell Phone:	
E-Mail Address:	Additional Phone:	

INSURANCE INFORMATION	
Primary Insurance:	**Secondary Insurance**:
Policy Subscriber Name:	Policy Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Subscriber SSN:	Subscriber SSN:

RESPONSIBLE PARTY	
Name:	DOB:
Relationship to patient:	SSN:
Address:	City, State, Zip:
Home Phone:	Work Phone:

PARENT/LEGAL GUARDIAN	PARENT/LEGAL GUARDIAN
Parent/Legal Guardian Name:	Parent/Legal Guardian Name:
Address: (If different than pt)	Address: (If different than pt)
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:

EMERGENCY CONTACT		
In an emergency notify:		Relation:
Home Phone:	Work Phone:	Cell Phone:

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

ALL COPAYMENT, COINSURANCE AND DEDUCTIBLE AMOUNTS ARE DUE AT THE TIME SERVICE IS RENDERED.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I hereby authorize East Scottsdale Medical Care, PLLC to provide such medical services, either regular or emergency, as may be determined by my physician to be in the best interest (or the best interest of my dependent if I am signing as a parent or guardian). I also hereby authorize ESMC to furnish information to insurance carriers concerning my medical condition and treatments. I hereby assign to the physician all payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for any and all amounts not covered by insurance. In the event of default, I promise to pay collection costs and reasonable attorney fees as may be required to effect collection of this account.

I FURTHER ACKNOWLEDGE THAT I HAVE RECEIVED THE "HIPPA" NOTICE OF PRIVACY PRACTICES.

Signature of Patient or Parent: _____ Date: _____