AZ Sports Medicine

PHYSICIAN: **Dr. Erik Dean** **Dr. Amit Sahasrabudhe**

Last Name: ________________________________ First Name: ___________________________ MI: ________

Address: __________________________________ City: ____________________ State: ______ Zip: ________

Cell Phone #: ___________________ Home Phone #: ____________________ Work Phone #: _______________

Email: | | | | | | | | | | | | | | | | | | | | | | | |

Primary Care Physician: _______________________________________ Phone: ______________________

Referring Physician: _____________________________ Other: _______________ Phone: __________________

Date of Birth: _____________________ Gender: Male Female Marital Status: ______________________

Social Security #: _______________________ Employer/School: ____

Employment Status: ☐FT ☐PT ☐Not employed ☐Self-employed ☐Retired ☐Student ☐Active Duty

Emergency Contact: __________________________ Relationship: ________________ Phone: _______________

Federal Privacy Standards require the following information:

Race: ______________________ Ethnicity:_______________________ Primary Language: ___________________
(i.e. Caucasian/Hispanic/Asian) (i.e. American/ Mexican/German)

How did you hear about us?

☐ Home ☐ Family Member ☐ Friend ☐ Internet ☐ School Athletic Trainer

☐ Another Physician (Name of Physician):_____________________________ ☐ Other: _________________

Responsible Party/Insured Party Information: (Please fill out completely **if other than self**)

Name: ____ Relationship: ___________________________

Date of Birth: ____________________ SSN: __________________ Gender: Male Female

Address: ______________________________ City: ____________________ State: _______ Zip: ______________

Home Phone #: _________________________ Cell #: ___________________ Work #: _______________________

E-Mail: ______________________________ Responsible/Insured Party's Employer: _________________________

Insurance Information:

Primary Insurance: _____________________________ Secondary Insurance: _______________________________

Policy Holder: ________________________________ Policy Holder: ____________________________________

Policy ID#: __________________________________ Policy ID#: ______________________________________

Group #: ____________________________________ Group #: ____

Insurer's Address: ____________________________ Insurer's Address: _______________________________

If the primary policy holder is anyone other than you, please fill out Responsible Party/Insured Party Information above.

Signature: ____ Date: ___________________