AZ Sports Medicine

Dr. Erik Dean **Dr. Amit Sahasrabudhe** **Dr. Stacey Dault**

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone #: _____ ▫ Cell▫Home Work Phone #: _____

Email:

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ _____ Phone: _____

Date of Birth: _____ Gender: Male Female Marital Status: _____

Social Security #: _____ Employer/School: _____

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: _____