



We would like to take this opportunity to welcome you to SPECTRUM MEDICAL GROUP. Please be advised that we will need your mailing address and all your health insurance information before we can actually confirm your appointment.

If you have confirmation through ZOCDOC you have 48 hours to contact the office with the required information or the appointment will be cancelled.

Thank You,

Spectrum Medical Group, PC

602-604-9500



Thank you for choosing our office: In order to serve you properly, we need the following information.  
Please Print. All information will be confidential.

**PATIENT REGISTRATION FORM**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ APT# \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
SOCIAL SECURITY#: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ GENDER: MALE FEMALE  
HOME PHONE #: \_\_\_\_\_ CELL PHONE # \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_  
LANGUAGE: \_\_\_\_\_ RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_ DECLINED \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

- ADVERTISING – LOCATION \_\_\_\_\_
- YELLOW PAGES – BOOK \_\_\_\_\_
- INTERNET – WEBSITE/SEARCH ENGINE \_\_\_\_\_
- ZOCCDOC
- OTHER \_\_\_\_\_

**EMERGENCY CONTACT**

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
NAME OF PREVIOUS PHYSICIAN: \_\_\_\_\_ PHONE#: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY: _____	SECONDARY: _____
ADDRESS: _____	ADDRESS: _____
CITY, STATE, ZIP: _____	CITY, STATE, ZIP: _____
PHONE: _____	PHONE: _____
POLICY HOLDER NAME: _____	POLICY HOLDER NAME: _____
RELATIONSHIP TO PATIENT: _____	RELATIONSHIP TO PATIENT: _____
EMPLOYER: _____	EMPLOYER: _____
POLICY#: _____	POLICY #: _____
GROUP#: _____	GROUP#: _____
POLICY HOLDER SEX: MALE/FEMALE DATE OF BIRTH: _____	POLICY HOLDER SEX: MALE / FEMALE DATE OF BIRTH: _____

**SPECTRUM MEDICAL GROUP, PC**

I hereby authorize Spectrum Medical Group to release any medical information necessary to referring physicians or to process insurance claims relation to the medical care rendered by Spectrum Medical Group.

PATIENT SIGNATURE OR LEGAL GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

**FINANCIAL AGREEMENT**

The financial policy of Spectrum Medical Group, PC has been fully explained to me and I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I hereby authorize Spectrum Medical Group, PC to obtain in my behalf, any insurance information covered by "The Privacy Act" from my insurance company(s) file(s). I hereby authorize payment directly to the physician(s) for medical and/or surgical benefits.

PATIENT SIGNATURE OR LEGAL GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_