

**StatClinix PLC**

PO Box 1649

Scottsdale, AZ 85252

(480) 374-7356

**PATIENT INFORMATION**

|                           |   |                 |                |                                    |           |   |            |
|---------------------------|---|-----------------|----------------|------------------------------------|-----------|---|------------|
| NAME (Last, First Middle) |   |                 | MRN            | SSN#                               | BIRTHDATE | LANGUAGE                                  | SEX        |
| LOCAL ADDRESS             |   | CITY, STATE ZIP |                | REFERRING PHYSICIAN                |           | SECONDARY/BILLING ADDRESS (if Applicable) |            |
| HOME PHONE                | DAY PHONE   | EMAIL ADDRESS   |                | PRIMARY CARE PROVIDER              |           | CITY, STATE ZIP                           |            |
| MARITAL STATUS            | STUDENT STATUS<br><input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time | SMOKER (Y/N)?   | VETERAN (Y/N)? | EMERGENCY CONTACT NAME             |           | CONTACT PHONE                             | HOME PHONE |
| PRIMARY EMPLOYER          |   |                 |                | SECONDARY EMPLOYER (if Applicable) |           |   |            |
| ADDRESS                   |   |                 |                | ADDRESS                            |           |   |            |
| CITY, STATE ZIP           |   |                 |                | CITY, STATE ZIP                    |           |   |            |
| WORK PHONE                |   |                 |                | WORK PHONE                         |           |   |            |

**RESPONSIBLE PARTY INFORMATION (if Different than above)**

|                           |   |                 |                |   |          |            |
|---------------------------|---|-----------------|----------------|---|----------|------------|
| NAME (Last, First Middle) |   |                 | SSN#           | BIRTHDATE                                 | LANGUAGE | SEX        |
| LOCAL ADDRESS             |   | CITY, STATE ZIP |                | SECONDARY/BILLING ADDRESS (if Applicable) |          |            |
| HOME PHONE                | DAY PHONE   | EMAIL ADDRESS   |                | CITY, STATE ZIP                           |          |            |
| MARITAL STATUS            | STUDENT STATUS<br><input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time | SMOKER (Y/N)?   | VETERAN (Y/N)? | PRIMARY CARE PROVIDER                     |          | HOME PHONE |
| RELATIONSHIP TO PATIENT   |   |                 |                |   |          |            |

**PRIMARY INSURANCE**

|                              |  |       |                  |  |                 |  |
|------------------------------|--|-------|------------------|--|-----------------|--|
| NAME OF INSURANCE COMPANY    |  |       | POLICY#          |  |                 |  |
| NAME OF INSURED              |  |       | GROUP#           |  |                 |  |
| ADDRESS OF INSURANCE COMPANY |  |       | COPAY AMT<br>\$  |  |                 |  |
| CITY, STATE ZIP              |  | PHONE | DEDUCTIBLE<br>\$ |  |                 |  |
| RELATIONSHIP TO PATIENT      |  |       | EFFECTIVE DATE   |  | EXPIRATION DATE |  |

**SECONDARY INSURANCE (if Applicable)**

|                              |  |       |                  |  |                 |  |
|------------------------------|--|-------|------------------|--|-----------------|--|
| NAME OF INSURANCE COMPANY    |  |       | POLICY#          |  |                 |  |
| NAME OF INSURED              |  |       | GROUP#           |  |                 |  |
| ADDRESS OF INSURANCE COMPANY |  |       | COPAY AMT<br>\$  |  |                 |  |
| CITY, STATE ZIP              |  | PHONE | DEDUCTIBLE<br>\$ |  |                 |  |
| RELATIONSHIP TO PATIENT      |  |       | EFFECTIVE DATE   |  | EXPIRATION DATE |  |

I certify that the information provided is true and accurate. I assign any payable benefits to be paid directly to Emergency Professional Services, PC and authorize them to submit claims on my behalf and release any information required to obtain payment for my care and treatment. I understand that I am ultimately responsible for payment of any services. I have had the opportunity to review the HIPAA Notice of Privacy Practices and any questions were addressed.

I authorize you to release information regarding my care to the following:

SIGNATURE OF PATIENT/GUARDIAN

DATE