Shady Canyon Medical Group

NEW PATIENT INFORMATION

Patient Name: ______________________________, ________________________________ Sex: ☐♀Female ☐♂Male
LAST FIRST

Date of Birth: ______________ Social Security #:______ - _____ -_______ Preferred language: ____________________

Home Address:____
STREET

____ ______ ______________
CITY STATE ZIP

Contact Numbers : Home# _____________________________ Cell# ___________________________________

Work#__________________________ Email: ____

Emergency Contact: ____________________________ ______________________ ____________________
NAME PHONE RELATIONSHIP TO PATIENT

Pharmacy Name and location: ___________________________________ Pharmacy#: ____________________

INSURANCE INFORMATION

Name of Insured:____ **Date of Birth**: ____________________
(IF DIFFERENT THAN ABOVE) (IF DIFFERENT THAN ABOVE)

Relationship to Patient: ______________________________ Social Security #:_______ - ______ -_________
(if other than SELF)

Insurance Company Name:___________________________________ Employer: ____________________________

****Primary Insurance**
- ☐ **HMO** ID# ____________________________
- ☐ **PPO**
- ☐ **Medicare** Group#__________________________
- ☐ **Caloptima**
- ☐ **Tricare**
- ☐ **None**

****Secondary Insurance**
- ☐ **HMO** ID# ____________________________
- ☐ **PPO**
- ☐ **Medicare** Group#__________________________
- ☐ **Caloptima**
- ☐ **Tricare**
- ☐ **None**

1) I hereby request and authorize Shady Canyon Medical Group Inc. to treat my conditions as my physician's judgment may indicate, and to use whatever diagnostic and/or therapeutic procedures necessary. *A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.*

______________________________________ ____________________
Patient Signature Date

2) I hereby request payment directly to Shady Canyon Medical Group Inc. of the surgical and/or medical benefits. I understand that I am financially responsible for the charges not covered by my authorization. I further agree, in the event of non-payment, to bear the cost of reasonable legal fees should this be required. If my bank fails to pay for any reason or in the case of returned checks, there will be a $20 handling fee for each transaction.

______________________________________ ____________________
Patient Signature Date

3) I hereby authorize Shady Canyon Medical Group Inc. to disclose when requested by the above named insurance carrier or its representatives any and all information with respect to any illness(es) or injury(ies), medical history or treatment and copy all medical records.

______________________________________ ____________________
Patient Signature Date