



**Phone (480) 585-0804**  
 Desert Mountain OB/GYN  
 14220 Northsight Blvd #150  
 Scottsdale, AZ 85260

PLEASE PRINT FULL DETAILS

**DESERT MOUNTAIN OB/GYN, P.O.**

This information will help the Doctor serve your health needs more effectively.

Today's Date \_\_\_\_\_

PATIENTS NAME	S	M	D	W	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
STREET ADDRESS	CITY AND STATE				ZIP CODE	HOME PHONE NO.	
PATIENTS EMPLOYER	OCCUPATION (Indicate if student)				How long employed?	BUSINESS PHONE NO.	
EMPLOYERS STREET ADDRESS	CITY AND STATE				ZIP CODE	CELL PHONE NO.	
SPOUSE OR PARENT NAME						SPOUSE OR PARENT DATE OF BIRTH	
SPOUSE OR PARENT EMPLOYER	SPOUSE OR PARENT OCCUPATION				HOW LONG EMPLOYED ?	BUSINESS PHONE NO.	
EMPLOYERS STREET ADDRESS	CITY AND STATE				ZIP CODE		
IS IT OK TO LEAVE MESSAGES ON PHONE #'S LISTED <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, WITH WHOM DO WE WE CONTACT? _____							

Whom should we contact in case of emergency? (Relative not living with you)

NAME	RELATIONSHIP	HOME PHONE NO.	
STREET ADDRESS	CITY AND STATE	ZIP CODE	BUSINESS PHONE NO.

WHO REFERRED YOU TO OUR OFFICE		
PRIMARY CARE PHYSICIAN	FAX NO.	PHONE NO.
STREET ADDRESS, CITY, STATE AND ZIP CODE		

I authorize Desert Mountain OB/GYN to release Medical information to my PCP or referring physician

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

AUTHORIZATION to release information and assignment of benefits.

I authorize payment of medical benefits to the provider for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and I will be bound by the signature as though I personally signed the claim. I authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collections agency, I will be responsible for any collection and/or legalities. I have read and understand the office policy and procedures.

**Patient Privacy** Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this Notice. However we would like your acknowledgment that you have been notified that the practice has such a Notice of Privacy Practices.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_