IM SPECIALIST, INC

PATIENT REGISTRATION

2737 West Baseline Road, Suite 24, Tempe, Arizona 85283 (602) 437-4800

Date / Fecha _____/_____/_____

Last / Apellido ____________ First / Nombre ____________ Home Phone No. / No. Telefono (______)__________ Work Phone No. / Telefono Del Trabajo (______)__________

Street Address / Direccion ____________ Cellular Phone No. / (______)-__________

City / Ciudad ____________ State / Estado ______ Zip Code / Zona Postal ________ Employer / Empleo ____________

Social Security No. / No. Seguro Social ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Martial Status / Estado Martial S M D W

Employer Address / Direccion de Empleo ____________

Date of Birth / Fecha de Nacimiento ______/_____/______ Age / Edad ________ Sex / Sexo M F Occupation / Ocupacion ____________

INSURANCE INFORMATION / INFORMACION DE SEGURO

Primary Insurance / Seguro Principal ____________ **Subscriber**/policy No. / No. Poliza ____________ **Group** Number ____________

Secondary Insurance / Seguro Secundario ____________ **Subscribe**r/Policy No. / No, Poliza ____________ **Group** Number

Insurance Policy Holder Information / Persona Responsable para la cuenta:

Last / Apellido ____________ First / Nombre ____________ Date of Birth _____/____/_____ Cellular Phone No. Celular (_______)-__________ Relation / Relacion ____________

Emergency contact / Contacto de Emergencia:

First Name / Nombre ____________ Last Name / Apellido ____________ Relation / Relacion ____________

Home Phone No. / No. de Telefono (_______)-__________ Cell Phone No. / Cellular (_______)-__________

Preferred Pharmacy / Farmacia Preferida ____________________

Referred By / Referido Por: ____________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS / AUTORIZACION DE PAGOS Y INFORMACION

I request that payment of authorized insurance benefits from any applicable insurance carrier be made on my behalf to IM Specialist for any services furnished to me by the provider. I authorize medical information needed to determine these benefits or the benefits payable for the related services be released to the insurance company and its agents. **I understand that even though I have some type of insurance coverage, I am responsible for the payment of services**.

Yo autorizo pagos de beneficios a IM Specialist, Inc. por servicios recibidos. Yo autorizo hacer publico cualquier informacion necesaria a la compania de seguro para determinar beneficios**. Yo entiendo que aunque tenga seguro, yo sere responsable por los servicios.**

✘____________________ _______/______/_______

Signature of Patient/ Firma de Paciente **Date / Fecha**

Provide your email!

Please provide us with your email address so that we may setup your patient portal account, where you can access your lab results and more!

Email: ____________________@____________________.com