West Horizon Medical Center

395 N. Silverbell Rd, Suite 245 Tucson AZ 85745

Tel: (520) 622-7675 Fax: (520) 628-1024

Patient Name: _____ _____ _____
Last **First** **Middle**

Permanent Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____

Cell Phone: (_____) _____ - _____ **Email:** _____

Date of Birth: _____ / _____ / _____ **Age:** _____ **Race:** _____
Month **Day** **Year**

SS Number: _____ / _____ / _____ **Sex:** ___Female ___Male

Drivers License Number: _____ **State:** _____

Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced

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In Case of Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone: (_____) _____ - _____

Default Pharmacy (Name / Address): _____

_____

CONSENT TO TREATMENT: I hereby grant my authorization and consent to ongoing routing treatment and procedures for the below named patient by West Horizon Medical Center. I hereby grant West Horizon Medical Center permission to view Rx Prescription history from any external sources.

ASSIGNEMNT OF BENEFITS: I hereby authorize my insurance benefits be paid directly to West Horizon Medical Center.

RELEASE OF INFORMATION: I authorize West Horizon Medical Center to release information to my insurance carrier, which may be required in the processing of a claim for coverage.

Signature: _____ **Today's Date:** _____