



**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

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.

**ASSIGNMENT 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: \_\_\_\_\_