



West Horizon Medical Center

1601 N. Tucson Blvd, Ste 18 Tucson AZ 85716

Tel: (520) 622-7675 Fax: (877) 870-9161

Change of Address Form

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: Male / Female / _____

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 routine 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 to 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: _____