Print Form

Banner Health®

PATIENT INFORMATION:

NAME (Last, First, Middle)			SSN#	SEX	BIRTHDATE	MARITAL STATUS
LOCAL ADDRESS	CITY, STATE, ZIP		EMERGENCY CONTACT NAME			
HOME PHONE	WORK PHONE	CELL PHONE	EMERGENCY CONTACT PHONE		RELATIONSHIP TO PATIENT	
E-MAIL			PRIMARY CARE PHYSICIAN (PCP)		PCP PHONE	
ALTERNATE ADDRESS (If Applicable)	CITY, STATE, ZIP		REFERRED BY			

RESPONSIBLE PARTY INFORMATION (if applicable, please X below)

☐ **Insured Spouse** ☐ **Parent** ☐ **Guardian**

NAME (Last, First, Middle)			
ADDRESS			
HOME/CELL PHONE	RELATIONSHIP TO PATIENT		
SSN#	SEX	BIRTHDATE	MARITAL STATUS

☐ **Additional Parent** ☐ **Additional Guardian**

NAME (Last, First, Middle)			
ADDRESS (If Applicable)			
HOME/CELL PHONE	RELATIONSHIP TO PATIENT		
SSN#	SEX	BIRTHDATE	MARITAL STATUS

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#
CUSTOMER SERVICE PHONE NUMBER	EFFECTIVE DATE:
CLAIMS MAILING ADDRESS (IF KNOWN)	
NAME OF INSURED	
PRIMARY EMPLOYER	
EMPLOYER ADDRESS	EMPLOYER PHONE
RELATIONSHIP TO PATIENT	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#
CUSTOMER SERVICE PHONE NUMBER	EFFECTIVE DATE:
CLAIMS MAILING ADDRESS (IF KNOWN)	
NAME OF INSURED	
SECONDARY EMPLOYER	
EMPLOYER ADDRESS	EMPLOYER PHONE
RELATIONSHIP TO PATIENT	

I authorize payment of benefits to Banner Health for professional services rendered. This is a direct assignment of benefits of my rights and benefits under my insurance policy. I authorize the release of all medical information necessary to process my claims. I authorize direct payment of benefits from my insurance company. I understand that I am responsible for any unpaid balance for services received but not covered under my insurance policy.
I, the undersigned, hereby authorize Banner Health Physicians to administer such treatment considered medically necessary during the course of my examination. By also signing below, I hereby acknowledge that I have received a Notice of Privacy Policy.

Name of Preferred Pharmacy, Address & Phone:

_____

I authorize the following individuals to receive information regarding my care. A separate release is required for release of copies of records.

1. _____ 2. _____ 3. _____

May we leave a message on your voicemail at home and cell? Yes ____ No ____

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE