



# KyreneInternalMedicine

Caring for Teens, Adults & Seniors

4545 E Chandler Blvd, Ste 201,  
Phoenix AZ 85048

[www.kyreneinternalmedicine.com](http://www.kyreneinternalmedicine.com)

Phone: 480-598-4145

Fax: 480-598-4346

## ALL Fields are REQUIRED

PATIENT INFORMATION							
Last Name		First Name			Middle Initial		
Social Security Number				Date of Birth			
Sex Female      Male		Marital Status Single      Divorced      Separated      Married      Widowed      Partnered					
Address					City	State	Zip
Home phone		Mobile Phone		Work Phone		Preferred Phone Home      Mobile      Work	
ALTERNATE Address if any					City	State	Zip
<b>How did you hear about our office</b> Family      Friend      Newspaper      Website      Yellow Pages      Other:							
<b>Race:</b>		American Indian/Alaska Native		Asian Black or African American		Hispanic	<b>Etnicity:</b>
		Native Hawaiian and Other Pacific Islander		Other		White	Hispanic/Latino
				Two or more			Non Hispanic/Latino
Emergency Contact Name		Emergency Contact Phone:			Preferred Communication Method:		
		-      -			Mail      Phone      Secure Messaging		
CONFIDENTIAL CLEARANCE AND TREATMENT AUTHORITY (IF ANY)							
Name		Relationship			DOB		Phone

## Please Fill This Portion if You Have Insurance

PRIMARY INSURANCE							
Insurance name							
Patient's Relation to Insured Self      Spouse      Child      Other				Insurance ID		Is Insurance through a company Yes      No	Group Number
<b>Insured Information if patient is not primary insured</b>							
Last Name		First Name		Sex Female      Male		Date of Birth	
Address					City	State	Zip
Phone		Co Pay		Employer Name			
SECONDARY INSURANCE							
Insurance name							
Patient's Relation to Insured Self      Spouse      Child      Other				Insurance ID		Is Insurance through a company Yes      No	Group Number
<b>Insured Information if patient is not primary insured</b>							
Last Name		First Name		Sex Female      Male		Date of Birth	
Address					City	State	Zip
Phone		Co Pay		Employer Name			



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**GUARANTOR: This is the person responsible for payment of medical services. Check one box**

Patient

Guarantor

Third Party (Not Medical Insurance)

## PATIENT INFORMATION

Last Name	First Name	Middle Initial	Date of Birth
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**ALL Fields are REQUIRED**

## GUARANTOR INFORMATION

Guarantor Last Name	Guarantor First Name	Guarantor Middle Initial	
Guarantor Social Security Number	Guarantor Date of Birth		
Guarantor Sex Female    Male	Guarantor Relation to Patient: Parent                  Spouse                  Sibling                  Other		
Guarantor Address	City	State	Zip
Guarantor Home phone	Guarantor Mobile Phone	Guarantor Work Phone	Guarantor Preferred Phone Home    Mobile    Work
Guarantor ALTERNATE Address if any	City	State	Zip

## THIRD PARTY INFORMATION ex, Attorney, Trust, etc

Name of Company			
Address	City	State	Zip
Phone	Fax	Email	

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Date**

