KyreneInternalMedicine
Caring for Teens, Adults & Seniors

4545 E Chandler Blvd, # 201 Phoenix, AZ 85048 www.kyreneinternalmedicine.com Phone: 480-598-4145 Fax 480-598-4145

Please complete entire form so we can set up your account then you will use the ipad or kiosk to complete your check in.

PREFIX ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Sir ☐ Dr			
Formal Last Name		Formal First Name	
Suffix ☐ II ☐ III ☐ IV ☐ Jr ☐ Sr		Middle Initial	
Formal Previous Name (If this is a Name Change)		Preferred Name (What can we call you informally, if any)	
Address Line 1			
Address Line 2	City	State	ZIP
Primary Phone		Personal Email Address	
IS THIS A CELL PHONE?	YES ☐ NO ☐	I DONT HAVE ONE ☐ WILL NOT PROVIDE ☐	
* Your cell phone number is needed to send you text messages including televisits links, appointment reminders etc		* Providing your email allows us to create your secure personal account to contact us, get copies of labs, records etc	
BIRTH SEX ☐ MALE ☐ FEMALE		**SSN**	

GUARANTOR: This is the person responsible for payment of medical bills.

I am responsible for my own Medical Bills ☐ YES ☐ NO
If you selected YES, skip this section, If NO and some else is responsible, complete this section

Guarantor Last Name	Guarantor First Name	Guarantor Middle Initial	
Guarantor Social Security Number	Guarantor Date of Birth	Guarantor Phone	Guarantor Sex ☐ F ☐ M
Guarantor Address Line 1 (Same as my address ☐)			
Guarantor Address Line 2			
Guarantor City	Guarantor State	Guarantor ZIP	

EMERGENCY CONTACT: In case of an emergency who do we contact.

Do you AUTHORIZE us to disclose your confidential medical information with this person YES ☐ NO ☐

Relation to Emergency Contact		Is Emergency Contact a patient here ☐ Yes ☐ No	
Emergency Contact Last Name	Emergency Contact First Name	Middle Initial	Emergency Contact Phone

KyreneInternalMedicine
Caring for Teens, Adults & Seniors

4545 E Chandler Blvd, # 201 Phoenix, AZ 85048 www.kyreneinternalmedicine.com Phone: 480-598-4145 Fax 480-598-4145

PRIMARY INSURANCE				
Name of Insurance				
Your subscriber ID		Group Number if any		
Are you the primary insured ☐ **YES** ☐ **NO** **If NO, complete the rest**	How are you related to the primary insured? ☐ **Spouse** ☐ **Child** ☐ **Other**			
Last Name	First Name	Middle Initial	Date of Birth	Sex ☐ F ☐ M
Address Line 1 (Same as my address ☐)				
Address Line 2	City	State	Zip	

SECONDARY INSURANCE				
Name of Insurance				
Your subscriber ID		Group Number if any		
Are you the primary insured ☐ **YES** ☐ **NO** **If NO, complete the rest**	How are you related to the primary insured? ☐ **Spouse** ☐ **Child** ☐ **Other**			
Last Name	First Name	Middle Initial	Date of Birth	Sex ☐ F ☐ M
Address Line 1 (Same as my address ☐)				
Address Line 2	City	State	Zip	

PHARMACY DETAILS

Pharmacy Name	City
Phone	Zip Code

HIPAA CONTACT INFORMATION: This is the person you AUTHORIZE this office to disclose your confidential medical information to			
Relation to HIPAA Contact	Is HIPAA Contact a patient here ☐ Yes ☐ No If Yes, no address needed		
HIPAA Contact Last Name	HIPAA Contact First Name	Middle Initial	HIPAA Contact Phone

4545 E Chandler Blvd, # 201 Phoenix, AZ 85048 www.kyreneinternalmedicine.com Phone: 480-598-4145 Fax 480-598-4145

CURRENT MEDICATION LIST AS OF _____ /_____/_____

MEDICATION	DOSAGE	HOW MANY TIMES DO YOU TAKE IT?

ALLERGIES
