KyreneInternalMedicine
Caring for Teens, Adults & Seniors

4545 E Chandler Blvd, Ste 201,
Phoenix AZ 85048
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

How did you hear about our office
☐ Family ☐ Friend ☐ Newspaper ☐ Website ☐ Yellow Pages ☐ Other:

Race: ☐ American Indian/Alaska Native ☐ Asian Black or African American ☐ Hispanic ☐ Native Hawaiian and Other Pacific Islander ☐ Other ☐ Two or more ☐ White

Etnicity: ☐ Hispanic/Latino ☐ 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

Email Address: _____

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

Insured Information if patient is not primary insured

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

Insured Information if patient is not primary insured

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

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**

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PATIENT'S CURRENT MEDICATION LIST AS OF _____

Last Name	First Name	Date of Birth

MEDICATION	DOSAGE	HOW MANY TIMES DO YOU TAKE IT?

Allergies: _____

Pharmacy: _____ Phone:_____ Crossroads or Address:_____