Dr. Brian Marks DO PC | Desert Breeze Internal Medicine

PATIENT NAME_____SS#_____

DATE OF BIRTH_____SEX (M / F) MARITAL STATUS (S / M / W / D)

PRIMARY ADDRESS_____APT#_____

CITY_____STATE_____ZIP CODE_____

HOME # _____MOBILE #_____WORK # _____

ALTERNATE ADDRESS_____APT#_____

CITY_____STATE_____ZIP CODE_____

EMAIL ADDRESS_____EMPLOYER_____

Race (African American/Asian/Caucasian/Hispanic/Other) **Ethnicity** (Hispanic-Latino/Not Hispanic-Latino/ Refused)

PRIMARY INSURANCE

NAME_____

POLICY#_____

GROUP #_____

INSURED'S NAME_____

DATE OF BIRTH_____

INSURED'S SS#_____

SECONDARY INSURANCE

NAME_____

POLICY # _____

GROUP # _____

INSURED'S NAME _____

DATE OF BIRTH _____

INSURED'S SS# _____

Who May Receive Information Regarding Your Protected Health Information?

Name_____ Date of Birth_____

Name_____ Date of Birth_____

Name_____ Date of Birth_____

May we email you and/or leave messages regarding test results, appointments and Physician referrals?
Y / N

I have received a copy of the Privacy Rules for Desert Breeze Internal Medicine and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by providing written notification to Desert Breeze Internal Medicine
Signature_____Date_____
I authorize Desert Breeze Internal Medicine to release any information required to process my insurance claim and authorize my insurance benefits to be paid directly to Desert Breeze Internal Medicine. I understand that I am financially responsible for non- covered services or expenses
Signature_____Date_____

Emergency Contact & Phone #_____