

WELCOME TO OUR OFFICE
Scott Rigden, M.D., P.C.
2410 W Ray Road, Suite 4
Chandler, AZ 85224
480-820-4297 Phone 480-838-4953 Fax

Chart # _____
(Office Only)

PATIENT INFORMATION

DATE OF BIRTH: _____

NAME: _____ SOCIAL SECURITY #: _____

ADDRESS: _____
(STREET) (APT #) (CITY) (STATE) (ZIP)

PHONE: _____
(PRIMARY) (SECONDARY)

OTHER ADDRESS: _____

MARITAL STATUS: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____ PHONE: _____

RESPONSIBLE PARTY (IF PATIENT IS UNDER 18 YEARS OF AGE OR SPOUSE HAS PRIMARY INSURANCE POLICY)

NAME: _____ SOCIAL SECURITY NO. _____

PRIMARY INSURANCE: _____ POLICY #: _____

BILLING ADDRESS: _____ GROUP #: _____

CO-PAY \$ _____

NAME OF LABORATORY CONTRACTED WITH INSURANCE (i.e. LAB CORP/SONORA QUEST) _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

ASSIGNMENT AND RELEASE: I CERTIFY THAT THE ABOVE IS CORRECT. I GIVE MY PERMISSION TO RELEASE INFORMATION TO MY INSURER. I HEREBY AUTHORIZE MY BENEFITS TO BE PAID DIRECTLY TO SCOTT RIGDEN, M.D., P.C.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES NOT COVERED BY MY INSURANCE.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____