Welcome To Thunderbird Internal Medicine

Patient Name: _____ Appointment Date: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____Work Phone: _____
Date of Birth: _____ Social Security #:_____ Gender: _____

Marital Status:	☐ Divorced ☐ Married ☐ Partner ☐ Single ☐ Unknown ☐ Widowed ☐ Legally Separated	Race:	☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ American Indian ☐ Other ☐ Refused	Ethnicity:	☐ Hispanic ☐ Not Hispanic ☐ Refused	Language:	☐ English ☐ Spanish ☐ Vietnamese ☐ Mandarin Chinese ☐ Hungarian ☐ Other

Are you currently employed? Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Disabled ☐
Employer: _____Phone#: _____
Address: _____ City: _____ State: _____ Zip Code: _____
**Do you have insurance through YOUR employer? Yes ☐ No ☐

Primary Insurance: _____
Policyholder Name: _____ Relationship to patient: _____
Policyholder date of birth: _____ Policyholder's Employer:_____
Policy/ID #: _____ Group #: _____
Insurance Company Address: _____
City: _____ State: _____ Zip Code: _____

Secondary Insurance: _____
Policyholder Name: _____ Relationship to patient: _____
Policyholder date of birth: _____ Employer: _____
Policy/ID #: _____ Group #: _____
Insurance Company Address: _____
City: _____ State: _____ Zip Code: _____
****Do you have AHCCCS or Tertiary (3rd) Insurance**? ☐Yes ☐No
If yes, Plan Name/ID#: _____

Patient/Parent/Guardian Signature:

_____**Date:**_____