desert foothills
Family Medicine

Jessica A. Blanco M.D.

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Please print full details.
This information will help your doctor serve your health needs more effectively. **Today's Date** _____

Patient's Name	S	M	D	W	Sex	Age	Date of Birth	Social Security #
Street Address	City, State						Zip Code	Home Phone #
Employer	Occupation						Work Phone #	Cell Phone / Pager #
Referred By							Are you a student? ❑ yes ❑ no ❑ full-time ❑ part-time	

Emergency Contact Information

Name	Relationship to Patient	Home Phone #	Work Phone #
Street Address	City, State	Zip Code	Cell Phone / Pager #

Insurance Information

Primary Insurance Company Name	Street Address, City, State, Zip Code			Phone #
Name of Person Policy Issued To	Date of Birth	Policy #	Group #	Policyholder SSN
Employer of Policy Holder	Street Address, City, State, Zip Code of Employer			Work Phone #
Relationship to Patient	Is this an ... ❑ HMO ❑ PPO		Effective Date	Office Visit Copay
Secondary Insurance Company Name (if applicable)				
Street Address	City, State		Zip Code	Phone #
Name of Person Policy Issued To	Date of Birth	Policy #	Group #	Policyholder SSN
Relationship to Patient	Is this an ... ❑ HMO ❑ PPO	If an HMO, do you need a referral? ❑ yes ❑ no	Effective Date	Office Visit Copay

Authorization to Release Information / Assignment of Benefits (Please check each box)

❑ I acknowledge that all of the above information is true and correct and that it has been furnished to this office with full knowledge.

❑ I understand that I am **responsible for all charges for services rendered**, and that I or my designated responsible party are contractually bound to pay for said services, including all costs of collection and legal fees should collection become necessary.

❑ I hereby assign to Desert Foothills Family Medicine any insurance or other insurance company benefits made on my behalf for healthcare services provided by Desert Foothills Family Medicine. I understand that Desert Foothills Family Medicine has the right to refuse or accept assignment of such benefits. If these benefits are not assigned directly to Desert Foothills Family Medicine, I agree to forward to Desert Foothills Family Medicine all health insurance or third party payments that I receive for services rendered to me by them immediately upon receipt.

❑ I also authorize the release of all medical information necessary in accordance with HIPAA guidelines, except as specifically noted. A copy of those guidelines are posted in the office and have been offered to me.

Signature of Responsible Party	**Date**