BASSI CLINIC
YOUR HEALTH.OUR PRIORITY

11110 N Tatum Blvd., Ste 103, Phoenix, AZ 85028
Phone: 602.354.3311 • Fax: 602.354.3751

New Patient Information Form

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Other Social Security #: _____

Home address: _____

House number Street City State ZIP

Phone: _____(Preferred) _____(Secondary) Email: _____

Race: ☐ American Indian ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Hispanic ☐ Decline

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline

Occupation: _____ Employer: _____ Employer phone no: _____

Preferred Language: _____ Best way to contact you: _____

Preferred Pharmacy: _____ Pharmacy phone no: _____

Emergency contact name: _____ Relationship: _____ Phone: _____

How did you hear about us? _____

Responsible Party for this visit:

Last name: _____ First name: _____ MI_____

Relationship to patient: _____ DOB: _____ SS#: _____

Home address: _____

House number Street City State ZIP

Phone: _____ (Preferred)_____ (Secondary) Email:_____

Employer: _____ Employer phone: _____

Insurance Information

Primary Insurance: _____ ID#: _____

Subscriber name: _____ DOB: _____ SS#: _____

Relationship to patient: _____ Group#: _____

Secondary Insurance: _____ ID#: _____

Subscriber name: _____ DOB: _____ SS#: _____

Relationship to patient: _____ Group#: _____

I hereby certify that above information is true and correct to the best of my knowledge. I hereby authorize Bassi Clinic to release all medical information pertaining to my treatment, to my insurance company or other third parties, to obtain payment for the medical services. I understand that I am responsible for all charges regardless of insurance coverage. I hereby agree to pay for services rendered to the patient in the event that my insurance coverage does not pay. I understand that all balances not paid within 30 days of statement due date will accrue an interest charge in the amount of 1.5% per month/18% per annum. In the event of default, I promise to pay any collection costs and reasonable attorney fees, as may be required to collect for my services. I acknowledge that the photo IDs taken are used in patient recognition per HIPAA guidelines.

Patient Signature: _____ Date: _____