PATIENT'S NAME ______________________________ *DATE* __________

Last First M.I.

BIRTH PLACE __________ BIRTH DATE __________ SEX ☐ M ☐ F AGE ______

HOME ADDRESS ______________________________________

Number Street Apt# City State Zip Code

HOME# __________ CELL# __________ WORK# __________

PRIMARY LANGUAGE __________ SOCIAL SECURITY # __________ MARITAL STATUS __________

EMPLOYED BY __________________ OCCUPATION __________________

EMPLOYER'S ADDRESS __________________ BUSINESS PHONE# __________

AT WHICH NUMBER MAY WE LEAVE A MESSAGE? ☐ HOME ☐ WORK ☐ CELL ☐ OTHER ☐ NONE

NAME OF SPOUSE __________________ AGE ______ BIRTH DATE __________

SOCIAL SECURITY # __________________ BUSINESS PHONE # __________________

EMPLOYED BY __________________ OCCUPATION __________________

EMPLOYER'S ADDRESS ______________________________________

CLOSEST RELATIVE (other than spouse) IN CASE OF EMERGENCY:

NAME __________ RELATIONSHIP __________ PHONE __________

ADDRESS ______________________________________

Number Street Apt# City State Zip Code

WITH WHOM MAY THE DOCTOR DISCUSS YOUR MEDICAL CONDITION?

__________	__________	__________	__________
Name	Relationship	Name	Relationship

REFERRED BY ______________________________________

PRIMARY CARE PHYSICIAN __________________ PHONE __________

BY PROVIDING THE ABOVE INFORMATION, I AUTHORIZE CRAIG M. RUNDBAKEN DO, ITS EMPLOYEES OR ITS APPOINTED AGENTS TO CONTACT ME REGARDING MY CARE. I HEREBY AUTHORIZE ARIZONA INSTITUTE OF RESPIRATORY MEDICINE AND VALLEY FEVER CLINIC OR ITS APPOINTED AGENTS, TO INCLUDE REVIEW ACTIVITIES RELATED TO MY PHYSICAN'S PARTICIPATION WITH MY HEALTH PLAN. I FURTHER AUTHORIZE MY INSURANCE CARRIER TO POY DIRECTLY TO SAID PHYSICIAN GROUP ALL MEDICAL AND SURGICAL EXPENSE BENEFITS ALLOWABLE, AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY, AS PAYMENT TOWARD THE TOTAL MANNER, ANY BANACE OF SAID PROFESSIONAL SERVICE CHARGES OVER AND ABOVE THE INSURANCE PAYMENT. A PHOTOCOPY OF THIS AUTHORIZAITON SHALL BE AS EFFECTIVE AND VALID AS THE ORIGINAL.

SIGNATURE ______________________________ DATE __________