Banner Health

BMG Arizona West
Po Box 52696
Phoenix, AZ 85072-2696
(602) -

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (If Applicable)				
CITY, STATE, ZIP	HOME PHONE	CITY, STATE, ZIP		HOME PHONE		
PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN		CONTACT NAME		CONTACT HOME PHONE	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (If Applicable)
ADDRESS	ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (If Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (If Applicable)				
CITY, STATE, ZIP	CITY, STATE, ZIP				
HOME PHONE	HOME PHONE				
RELATIONSHIP TO PATIENT					

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
CITY, STATE, ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If Applicable)

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
CITY, STATE, ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

Circle one or more: Asian Black/African American Hispanic Native American/Alaskan Native Pacific Islander/Native Hawaiian White

I assign all medical and/or surgical benefits to which I am entitled, under private insurance, or any other health plan to Banner Health. I authorize the release of my medical information necessary to process claims and direct payment of benefits from my insurance company. I accept financial responsibility for all charges, including but not limited to, copayments and annual deductibles. I have received my Medical Treatment Agreement.
This includes my email and phone communication preferences, as well as, the Consent to Treat agreement.
Exisiting Patient Only: Would you like to make changes to the Medical Treatment Agreement at this time? Select One: Yes____ No____

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____