

# NORTH SCOTTSDALE INTERNAL MEDICINE - MARK J. LEWIS, MD, PLC

Name		Date of Birth	Gender (circle one) male    female	
Address		City	State	Zip code
Primary Phone for Contact	Secondary Phone for Contact		Social Security No.	
Detailed messages (labs, call back, results etc) may be left for me at (circle one):				
Primary #	Secondary #	Work	Email	No messages left anywhere
Marital status (circle one) single    married    divorced    widow    legally seperated    Partner			Email Address	
Employer			Work Phone	
Emergency Contact		Relationship	Emergency Contact phone	
Responsible Party Name (if patient is under 18 or other then patient)				
Address/City/State/Zip			Social Security No.	
Phone	Date of Birth	Employer Name & Phone #		
Primary Insurance Carrier			Phone	
Policy Holder Name (if other then patient)			Social Security No.	
ID/Policy No.	Group No.	Date of birth (of policy holder)		
Secondary Insurance Carrier			Phone	
Policy Holder Name (if other then patient)			Social Security No.	
ID/Policy No.	Group No.	Date of birth (of policy holder)		
PHARMACY NAME		Location	Phone	
Person(s) other then the patient may receive my medical records and or test results				
1 - Name		Phone		
2 - Name		Phone		
3 - Name		Phone		

I authorize my insurance company to pay directly any and all claims submitted from Mark J. Lewis, MD, PLC. I accept responsibility for any unpaid balance following insurance reimbursement or should insurance deny coverage for services for any reason and will pay the balance in a timely manner. If I have no insurance or it lapsed I will pay the bill.

Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to patient