Bradley K. Becker, D.O., P.L.L.C

18555 N. 79th Ave., Suite B-102, Glendale, AZ 85308 - Ph: 602-610-9111 Fax: 623-471-5180

PATIENT INFORMATION

NAME**:** ______________________________________ DOB: _______________ Age: _____

Street Address: ____

City: ______________________________________ State: ______________ Zip: ____________

SS#: ______________________________ Sex: Male Female

Phone Home: ______________________ Cel: _________________ Work: _________________

Email Address: ____

Preferred Pharmacy Address: ____

GUARANTOR INFORMATION

NAME**:** ______________________________________ DOB: _______________ Age: _____

Street Address: ____

City: ______________________________________ State: ______________ Zip: ____________

SS#: ______________________________ Sex: Male Female

Phone Home: ______________________ Cel: _________________ Work: _________________

Email Address: ____

INSURANCE INFORMATION

Primary Ins: ____ Start Date: ________________

Claim Address: ____

Policy #: _____________________________________ Group #: ________________________

Policy Holder: ________________________________ Relation to Patient: ________________

Employer: ___________________________________ DOB: ____________________________

Secondary Ins: ______________________________________ Start Date: _________________

Claim Address: ____

Policy #: _____________________________________ Group #: ________________________

Policy Holder: ________________________________ Relation to Patient: ________________

Employer: ___________________________________ DOB: ____________________________

Primary Physician: __________________________________ Phone: _____________________

Secondary Physician: ________________________________ Phone: _____________________

Emergency Contact: _________________________________ Phone: _____________________

By signing this form, I certify that the information provided is accurate and true to the best of my knowledge. I hereby authorize Dr. Bradley Becker, D.O. to furnish the above insurance company(ies) all medical information necessary to process any appropriate claims. I authorize payment of medical benefits to Bradley Becker, D.O. I understand that I am responsible for paying for services rendered, including attorney's fees and cost of collection in the event of default.

SIGNATURE: _______________________ **Date**: _______________________