



*North
Scottsdale*
FAMILY MEDICAL CENTER

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Patient Registration Form

(Please Print)

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial): _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Marital Status (Circle One): Single / Married / Divorced / Sep / Wid / Sig Other Sex: M / F

Phone Number(s) _____ where you can be reached and to leave messages:
() _____
() _____

E-mail Address: _____

Soc Sec #: _____ DOB: / /

Who referred you to our office? _____

INSURANCE INFORMATION

(Please give your insurance card to the person at the Front Desk)

Primary Policy Holders Name & DOB: _____

Primary Insurance: _____ Individual ID: _____

Group#: _____ Policy #: _____ Co-Pay Amt\$: _____

Employer Name & Phone Number: _____

EMERGENCY CONTACT:

Name and Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: () _____

The information above is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any unpaid balance. I authorize Brett Swenson MD PLLC, or any billing service and insurance company to release any information needed to process all claims. I am aware of HIPAA policies and Privacy Act of 1974.

Patient/Guardian Signature: _____ Date: _____