

Office of Dr. David A. Tallman & Dr. Darrienne Slater
8300 N. Hayden Rd
Suite A 111
Scottsdale, AZ 85258

Patient Information Form

All Information is Held in Strict Confidentiality

Patient Name _____ Age _____ Marital Status: M S D W
Permanent Address _____ Apt _____
City _____ State _____ Zip Code _____
Temporary Address _____ Apt _____
City _____ State _____ Zip Code _____
Home Phone# _____ Cell# _____ Work# _____
E-mail _____
Birth Date: Month _____ Day _____ Year _____ Country: USA other _____
Occupation _____ Years _____ Employer _____
Work Address _____ City _____ State _____ Zip _____
Previous Occupation _____ Years _____
Name of Spouse _____
Emergency Contact _____ Phone _____
Who referred you to this clinic _____
Primary Care Physician _____ Phone _____ City _____

Clinic policy requires payment at the time of service. Although the clinic does not bill insurance companies for non-accident related matters, the staff will gladly assist you in helping to receive insurance reimbursement for medical fees.

I understand and agree that health and accident insurance policies are an agreement between an insurance company and myself. I hereby authorize the physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees or court costs incurred as a result of collection efforts will be added to my account balance.

Patient's Signature Parent or Guardian Date

Thank You for Your Patience