

C. Steven Plimpton, M.D., P.C.

Ellen Franklin, CNM, MS

515 East Thomas Road

Phoenix, AZ 85012

Patient Information

DATE _____

Name _____

PLEASE PRINT

Last

First

Middle

() Single () Married () Divorced () Separated

Home Address _____

City _____ State _____ Zip Code _____

Home Telephone () _____ Work Telephone () _____

Birth Date _____ Age _____ Social Security No. _____

Occupation _____ Employer _____

Employer Address _____ City _____ State _____ Zip _____

Years Employed there _____ E-mail Address _____

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Spouse or Responsible Party () Check here if responsible party is yourself

Name _____

Relationship to you _____ Social Security Number _____

Birth Date _____ Age _____ Telephone _____

Employer _____ Address _____

City _____ State _____ Zip Code _____

IN CASE OF EMERGENCY NOTIFY

Name _____ Telephone _____

Relationship to you _____

REFERRED TO US BY: _____

PLEASE PRINT

C. Steven Plimpton, M.D., P.C.
Ellen Franklin, CNM, MS
515 East Thomas Road
Phoenix, AZ 85012

Primary Insurance Company _____

Insurance Address _____

City _____ State _____ ZipCode _____

Telephone Number _____

Insured Name _____

Insured ID Number _____ Group Number _____

Employer _____

Secondary Insurance Company _____

Insurance Address _____

City _____ State _____ ZipCode _____

Telephone Number _____

Insured Name _____

Insured ID Number _____ Group Number _____

Employer _____

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I authorize that the payment of medical benefits be made directly to the physician provider for any services rendered. I authorize any insurance company, organization, employer, hospital, or physician to release information with regards to claims and the expenses reported. I am aware that I am responsible for the charges incurred for my care and may be required to make payment for services not covered by my insurance carrier. I am also aware that if a referral from my primary physician was required for any of my visits and I failed to obtain this prior to my visit, then I may be required to pay for that visit.

Signature _____ Date _____

IN THE EVENT THAT THE PATIENT IS UNDER THE AGE OF EIGHTEEN (18) THIS MUST BE SIGNED BY GUARDIAN/PARENT OR RESPONSIBLE PARTY OVER THE AGE OF EIGHTEEN.
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I authorize this office to release any information pertaining to my care to a HOSPITAL where my care is planned and/or to my PRIMARY CARE PHYSICIAN or REFERRING PHYSICIAN. I am aware that this information may contain my diagnosis, examination findings, treatments, laboratory results and historical information provided by myself. This information may contain confidential HIV (AIDS), Communicable Disease, and/or substance abuse related information.

Signature _____ Date _____

I authorize the release of my medical information including appointments and test results via telephone, messaging system, and/or e-mail only to myself. I understand that no information will be given to individuals or institutions without my WRITTEN consent.

Signature _____ Date _____