MorrisHealth | Kevin Chan, DO, MS, MMM, PCEO, FASA, FAIHM.
3196 N. Windsong Drive | Prescott Valley, AZ 86314
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Patient Information Sheet

(Please print clearly)

Patient's Name:______________________________Nickname:___________________________ Sex: □M □F

Street Address:______________________________City: _____________________________ Zip:__________

Mailing Address:_____________________________City: _____________________________ Zip:__________
(if different)

Alternate Address: ___________________________City:_____________________________ Zip:__________

Home Phone:_____________________ Social Security #:_____________________ Birthdate:_____________

Cell Phone: _________________ Work Phone:__________________ Occupation/Employer:_______________

What is the best way to reach you on weekdays between 8:00 am-5:00 pm? Phone#:______________________

□ Married □ Single □ Divorced □ Separated □ Widowed Spouse's Name:__________________________
(Parent's name if patient is under 18; Legal Guardian's if applicable)

Spouse's Occupation/Employer:_______________________________ Work Phone:____________________
(Parent's Occupation/Employer/Work Phone if patient is under 18; Legal Guardian's if applicable)

IN CASE OF EMERGENCY, Notify:____________________________ Relationship:______________________
(Other than spouse/parent/guardian)

Home Phone:____________________ Employer:_____________________ Work Phone:_________________

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR PAYMENT OF FEES

Name:_________________________ Home Phone:_____________________ Relationship:______________

Address:________________________________City:_____________________Zip:_______________________

Employer/Occupation:____Work Phone:____________________

PRIMARY INSURANCE

☐ Medicare ☐ Other: ___________________________

Subscriber Name:_______________________________

ID#:_______________________Group #_____________

SECONDARY INSURANCE

Insurance Company:________________________

Subscriber Name:___________________________

ID#:___________________Group #____________

May we leave a message on your answering machine or with a family member regarding your test/exam results, appointments, billing information, or medication refill? ☐YES ☐NO

Who else can our office talk to regarding the above?

Name:____________________________ Relation to Patient:_________________Phone #:______________

- I understand that I am responsible for all the charges whether or not paid by Insurance. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office. In the event that I am entitled to health insurance or other benefits relating to my medical condition and available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill.

- I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges. A facsimile or photocopy of this authorization will be as valid as the original.

- I have received and read the Notice of Privacy Practice Statement.

Patient's Signature: ____ Date: __________________________

Parent's or Legal Guardian's Signature:__________________________Date:____________________________
(Parent must sign if patient is under 18; Legal Guardian must sign if applicable)