J. Dan Morris, M.D. | MorrisHealth
3194 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)