



PO Box 7904
Cave Creek, AZ 85327
Office Hours:
Mon-Thurs: 9am-4pm (closed 12pm-1pm)
Fri: 9am-12pm

Phone: 480-575-0576

Fax: 480-575-0512

www.doctorcareaz.com

Please print legibly

Date: _____

Patient's Name:

(Last) Middle (First)

Address:

(Street)

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell/Other: _____

Email Address: _____ Fax: _____

Social Security #: _____ Date of Birth: _____

Marital Status: _____

Emergency Contact/POA: _____ Phone: _____

Primary Insurance Provider: _____ Insurance #: _____

Secondary Insurance Provider: _____ Insurance #: _____

Credit Card Info (please circle one):

Visa MC AMEX Discover #: _____ Exp. Date: _____

Name of caregiver (if applicable): _____ Phone: _____

Case Manager: _____ Phone: _____

Fax: _____

Pharmacy: _____ Phone: _____

Fax: _____

What are your current diagnoses?:

Approx. Height: _____ Approx. Weight: _____

Is patient on Oxygen: Yes No (please circle one)

Is patient bedridden Yes No

In wheelchair Yes No

Drive scooter Yes No

Please list any known allergies:

Please include copies of all insurance cards and Social Security Cards!