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PATIENT INFORMATION SHEET

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security# _____ Sex: Male _____ Female _____

Address: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Employer: _____ Address: _____ Phone: _____

Occupation: _____ Whom to notify in case of emergency? _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Who referred you to our office: _____

Spouse Information

Name: _____ Occupation: _____

Employer Address & Phone _____

Patients Under 18 Years of Age

Name of Father: _____ Address & Phone: _____

Employer Name, Address & Phone: _____

Name of Mother: _____ Address & Phone: _____

Employer Name, Address & Phone: _____

Insurance Information

Primary Care Physician _____ Office Phone: _____

Address: _____

Primary Insurance: _____ Address: _____

ID # _____ Group # _____ Policy Holder' Name: _____

Policy Holder's DOB: _____ Policy Holders SS# _____

Secondary Insurance: _____ Address: _____

ID # _____ Group # _____ Policy Holder' Name: _____

Policy Holder's DOB: _____ Policy Holders SS# _____

I authorize the release of protected health information for the purpose of treatment, payment, and health care operations. I authorize fax transmission of medical records, if necessary. I authorize payment of insurance benefits to San Tan Allergy & Asthma. I understand that I am financially responsible for the charges not covered by my insurance. The HIPPA Privacy Notice for San Tan Allergy & Asthma has been given to me.

Patient/Responsible Party Signature: _____ Date: _____