Julie A. Wendt, MD, PLLC
21803 N. Scottsdale Rd, Ste 200
Scottsdale, AZ 85255
(480) 500-1902

REGISTRATION FORM

Today's date:	How did you hear about us?	Referred By:

PATIENT IFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Primary phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Email address:	Primary Care Physician:

INSURANCE INFORMATION

(Please give your insurance card(s) and ID to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Primary phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Parent	❑ Legal Guardian	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Parent	❑ Legal Guardian	❑ Other

AUTHORIZED INDIVIDUALS TO WHOM MEDICAL INFORMATION MAY BE RELEASED

Name:	Relationship to patient:	Birth date:	Primary phone no.: ( )
Name:	Relationship to patient:	Birth date:	Primary phone no.: ( )

PHARMACY INFORMATION

Pharmacy: Address:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Primary phone no.: ( )	Other phone no.: ( )