Melinda M. Martin, M.D.

907 Ainsworth Drive
Prescott, AZ 86305

3262 N. Windsong Drive, Ste A
Prescott Valley, AZ 86314

PATIENT INFORMATION

First Name_____ MI_____ Last Name_____

DOB_____ SSN_____ Marital Status: Single_____ Married_____ Divorced_____ Widowed _____

Mailing Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____ email_____

Employer Name_____ Employer Phone No._____

Primary Care Physician_____ Phone No._____

Emergency Contact Name_____ Phone No._____

Relationship to Patient_____ DOB_____

INSURANCE INFORMATION

Primary Insurance_____ Name of Cardholder_____

Insurance Address_____ DOB_____ SSN_____

_____ Relationship to Insured_____

Insurance Phone No._____

Secondary Insurance_____ Name of Cardholder_____

Insurance Address_____ DOB_____ SSN_____

_____ Relationship to Insured_____

Insurance Phone No._____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. My signature below indicates that I have read and understand all of the above as well as completing all questions with current information. **I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF WHETHER OR NOT I AM INSURED.** If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees in addition to the remaining balance.

Patient/Parent or Guardian Signature_____ Date_____