Office of Dr. David A. Tallman
8300 N. Hayden Rd
Suite A-111
Scottsdale, AZ 85258

Patient Information Form

All Information is Held in Strict Confidentiality

Patient Name_____ Age_____ Marital Status: M S D W

Permanent Address_____ Apt_____

City_____ State_____ Zip Code_____

Temporary Address_____ Apt_____

City_____ State_____ Zip Code_____

Home Phone#_____ Cell#_____ Work#_____

E-mail_____

Birth Date: Month_____ Day_____ Year_____ Country: USA other_____

Occupation_____ Years _____ Employer_____

Work Address_____ City_____ State_____ Zip_____

Previous Occupation_____ Years_____

Emergency Contact_____ Phone_____

Who referred you to this clinic_____

Primary Care Physician_____ Phone_____ City_____

Clinic policy requires payment at the time of service. Although the clinic does not bill insurance companies for non-accident related matters, the staff will gladly assist you in helping to receive insurance reimbursement for medical fees.

I understand and agree that health and accident insurance policies are an agreement between an insurance company and myself. I hereby authorize the physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees or court costs incurred as a result of collection efforts will be added to my account balance.

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Patient's Signature Parent or Guardian Date

Thank You for Your Patience