



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

REGISTRATION FORM

Today's date:				Referred By:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:		<input type="checkbox"/> Self	<input type="checkbox"/> Parent	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Parent	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> 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.: ()		



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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Julie A. Wendt MD, PLLC. I understand that I am financially responsible for any balance. I also authorize Julie A. Wendt MD PLLC or my insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

AUTHORIZATION TO VIEW AND OBTAIN EXTERNAL PRIScription HISTORY

I authorize the medical providers of Julie A. Wendt MD PLLC to view and obtain my external prescription history via electronic prescription services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff through these services, and may include prescriptions back in time for several years.

Patient/Guardian signature

Date

NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Julie A Wendt MD PLLC. The Notice of Privacy Practices also describes my rights and Julie A Wendt MD PLLC's duties with respect to my protected health information. The Notice of Privacy Practices can also be found on the Julie A Wendt MD PLLC and Relieve Allergy Asthma & Hives website at relieveaz.com.

Julie A Wendt MD PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing the relieveaz.com website.

Patient/Guardian signature

Date