Ace Health and Wellness Center
14815 N Del Webb Blvd, Sun City, AZ 85351
Ph.(623) 248-1717 | Fax.(623) 248-1688
www.acehealthclinic.com

PATIENT DEMOGRAPHIC FORM

Patient Information:

Last Name:	First Name:		MI:
Preferred name:	Social Security#:		Date of Birth: _____/_____/_____
Street Address:	City:	State:	Zip:
Home Phone: ☐ Preferred	Work Phone: ☐ Preferred		Cell Phone: ☐ Preferred
Gender: ☐ Female ☐ Male ☐ Other:_____	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated		
Race (Optional): ☐ Decline	Ethnicity (Optional): ☐ Decline		E-Mail Address:
Do you have a living will: ☐ YES ☐ NO If yes, please provide a copy for our records. Do you have a DNR? ☐ YES ☐ NO If yes, Please provide a copy for our records			

Emergency Contact:

Emergency Contact Name:	Relation:
Emergency Contact Phone#:	**CANNOT BE THE SAME NUMBER AS YOUR OWN**

Pharmacy Information:

Local Pharmacy:	Pharmacy Phone#:

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Pharmacy Major Cross Streets & City:	Mail Order Pharmacy name and Phone#:

Patient Name:_____ DOB:_____/_____/_____

Financially Responsible Party:

Is patient responsible party/guarantor: ☐ Yes ☐ No			
Name (Last,First, MI):		Relationship to patient:	
Street Address:	City:	State:	Zip:
Home Phone: ☐ Preferred	Work Phone: ☐ Preferred	Cell Phone: ☐ Preferred	
Occupation:	Employer:	Date of Birth:	

Insurance information:

Primary Insurance Company:	Policy#:	Group#:	
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____		Name of Subscriber (if other than patient):	
Gender: ☐ Female ☐ Male ☐ Other:_____	Subscriber DOB: _____/_____/_____	Employer of subscriber:	Subscriber Phone#:
Secondary Insurance Company:		Policy#:	Group#:
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____		Name of Subscriber (if other than patient):	

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Gender:	Subscriber DOB:	Employer of subscriber:	Subscriber Phone#:
☐ Female ☐ Male ☐ Other:_____	_____/_____/_____		

_____

Patient Name:_____ DOB:_____/_____/_____

I authorize Ace Health and Wellness Center to perform, evaluate and treat, as they deem necessary. I further authorize my insurance company to pay Ace Health and Wellness Center all medical benefits. I understand that ultimately, I am responsible for all charges not covered by my insurance as well as all deductibles, coinsurance, and copay amounts as determined by my insurance company. I understand that I will be responsible for all collection and legal fees if my account is placed with an outside collection agency. I hereby authorize Ace Health and Wellness Center to release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I certify that the information above is true and correct to the best of my knowledge and will notify Ace Health and Wellness Center of any changes to this information.

I also acknowledge and understand the practice's appointment policy. Established patients who fail to provide at least 24 hours' notice to cancel or reschedule an appointment may be charged a no-show fee of $25. Repeated no-shows or late cancellations may result in increased fees and, after multiple occurrences, dismissal from the practice. New patients who fail to attend their initial appointment may not be rescheduled. No-show fees are the patient's responsibility, are not billable to insurance, and are due at the next office visit.

By signing below, I acknowledge that the information I provided is correct to the best of my ability

Patient Signature:_____ Date:_____/_____/_____

Guarantor Signature_____Date:_____/_____/_____
(If other than patient)