Southwest Internal Medicine Group
Roberto Ruiz, M.D., F.A.C.P.
40th Street Medical Plaza - 16601 N. 40th St., Ste. 110 - Phoenix, Arizona 85032
(602) 253-0855 Fax (602) 253-0535
PLEASE FAX ALL CORRESPONDENCE TO: (602) 424-6986

PATIENT INFORMATION

Last Name	**First Name**			**MI**
Date of Birth	**Age**	**Sex:** ☐ **Male** ☐ **Female**	**Social Security**	
Mailing Address		**City**	**State**	**Zip Code**
Home Telephone # ( )	**Cell Phone #** ( )		**Work Telephone #** ( )	

Marital Status: ☐ **Single** ☐ **Married** ☐ **Legally Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Partner**

Who Referred You? _____

EMPLOYER INFORMATION

☐ **Full Time** ☐ **Part Time** ☐ **Retired** ☐ **Not Employed** ☐ **Self Employed** **Are you a Student?** ☐ **Y** ☐ **N** ☐ **Part-Time** ☐ **Full Time**

Employer	**Occupation**		**Telephone #** ( )
Employer Address	**City**	**State**	**Zip Code**

INSURANCE INFORMATION

1 Primary Insurance	**ID #**	**SS#**		**Group #**
Name of Insured	**Date of Birth**			**Insurance Telephone #** ( )
Insurance Address	**City**	**State**		**Zip Code**
2 Secondary Insurance	**ID #**	**SS#**		**Group #**
Name of Insured	**Date of Birth**			**Insurance Telephone #** ( )
Insurance Address	**City**	**State**		**Zip Code**

WHO MAY WE CONTACT IN CASE OF AN EMERGENCY?

Name	**Relationship**		**Telephone #** ( )
Address	**City**	**State**	**Zip Code**

I acknowledge and agree that if for some reason the insurance does not pay for services rendered at the time of examination, treatment and/or diagnostic services, I am responsible for all expenses accrued and will forward payment directly to Roberto Ruiz, M.D. I am also aware that if I do not cancel a scheduled appointment within 24 hours or if I am a "No Show" I will be subject to a $25.00 fee.

Signature _____ **Date** _____