Endo West
Jeff Arrington, MD
12842 South 3600 West #200
(801) 433-2190
(801) 433-2191 (fax)

PATIENT INFORMATION:

Patient Name	Marital Status	Gender	Date of Birth	Cell Phone
Current Address	City	State	Zip	Home Phone
Employer	Address			Work Phone
Social Security Number	Primary Care Physician		Referred by	
Preferred Pharmacy	Race		E-mail address	
Preferred Salt Lake Hospital				
Spouse's Name	Spouse's Date of Birth		Spouse's Work Phone	

RESPONSIBLE PARTY INFORMATION:

Name		Gender		Date of Birth
Mailing Address	City	State	Zip	Home Phone
Employer	Address			Work Phone
Relationship to Patient				

EMERGENCY CONTACT:

Name	Relationship	Daytime Phone Number

BILLING INFORMATION:

Primary Insurance	Card Holder	Group Number	Policy Number
Mailing Address	City	State	Zip
Secondary Insurance	Card Holder	Group Number	Policy Number
Mailing Address	City	State	Zip
Out of Network Benefit	Deductible	Co-Insurance	Out of pocket max

Consent to Treat and to Disclose Protected Health Information: I authorize the physician or physicians in charge of the care of the above named patient to administer anesthetics and/or medications and to perform such operations and/or diagnostic procedures as may be deemed necessary by the physician for the diagnosis and treatment of this patient.

The practice's Written Privacy Notice provides detailed information on how we may use and disclose protected health information. By signing this consent form, you acknowledge that you have received a copy of the Written Privacy Notice and are in agreement with our use and disclosure of protected health information for treatment, payment, and health care operations. Patients injured at work typically obtain information through their adjuster or employer. I have read and understand the above statements. Affixing my signature to this form represents my receipt of the Written Privacy Notice, my consent to treatment, and the above listed uses of protected health information.

Signature of Patient or Responsible Party Date