Welcome To

Wound Center of Tucson/Tucson Bariatric

3925 E Ft Lowell RD, Suite 104 Tucson, AZ 85712

PH 520-319-6000 FAX 520-319-6001

APPOINTMENT INTRODUCTION

What needs to be provided before your appointment:

-Photo ID and Insurance Card
-Current list of Medications, Vitamins and Supplements including dosages
-List of Medication Allergies
-Insurance Referral/Authorization if required
-If you have a Copay, it is due upon Check-in
For a Telemedicine Appt, please call before your appt

Prior Bariatric Patients:

We require a copy of your Operative Report from your surgeon, copies of any Recent Testing, ex: Labs, EGDs, CTs/MRIs

Wound Care Patients:

We will need the most current office notes regarding the reason you are being seen

We can assist you in obtaining any of these records, just fill out the

Disclosure of PHI Form

If you have any questions, or need Assistance please contact our office at 520-319-6000

Patient Registration

Last Name: _____First Name: _____Middle Initial: _____

Nick Name/Name you prefer to be called: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____Secondary Phone: _____

Email: _____

Date Of Birth: _____ SSN: _____

Sex: Male ___ Female___ Identity: _____ Pronouns: _____

Marital Status: _____

Preferred Language: _____

Race

____ American Indian/Native American

_____Asian

_____Native Hawaiian/Pacific Islander

_____Other _____

_____ Decline to specify

_____Black/African American

_____Hispanic/Latin American

_____White/Caucasian

Primary Care Physician Name: _____

Phone Number: _____

Referring Physician Name: _____

Phone Number: _____

Emergency Contact Information:

Name: _____

Phone Number: _____ Relationship: _____

Name: _____

Phone Number: _____ Relationship: _____

Please list any persons able to obtain Medical Information on your behalf. It is very important to fill this section out if you want someone to be able to access medical information if you are not able to contact us.

Name: _____ Phone: _____

Name: _____ Phone: _____

Advance Directive:

Do you have a Living Will: Yes _____ No_____

Does Anyone have Power of Attorney Over you? Yes _____ No _____

If yes, Name _____

Insurance Information

Primary:

Insurance Company: _____

Policy Number: _____ Policy Holders Name: _____

Date of Birth: _____ Policy Holders SSN: _____ Relationship: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Secondary:

Insurance Company: _____

Policy Number: _____ Policy Holders Name: _____

Date of Birth: _____ Policy Holders SSN: _____ Relationship: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Signature: _____ Date: _____