



Westside Primary Care Associates

Main Location: 14420 W. Meeker Blvd, Suite 207, Sun City West, AZ 85375

Buckeye Office: 865 S. Watson Road, Suite 108 Buckeye, AZ 85326

Phone: 623-267-6700 **Fax:** 623-267-6701 **Web:** westsidepca.com

Patient's Name (Last, First, MI): _____	
Patient's Phone Number: _____	Alt. Phone Number _____
Date of Birth: _____	Age: _____ Sex: M F SSN: _____
Email Address: _____	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Address: _____	
Apt. # _____	City: _____ State: _____
Zip: _____	AUTHORIZED TO LEAVE VOICE MAIL? YES ___ NO ___
Employment Status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Other: _____	
Emergency Contact: _____	Relationship: _____
Address: _____	Phone Number: _____
RELEASE OF INFORMATION: I hereby give permission to the person(s) listed above to receive information about my care. YES ___ NO ___	
INSURANCE INFORMATION	
Primary Insurance: _____	Policy/Member ID: _____
Patient is Subscriber/Policy Holder: Y N	
Secondary Insurance: _____	Policy/Member ID: _____
Patient is Subscriber/Policy Holder: Y N	
Pharmacy (retail)	
Name: _____	Phone: _____
Cross Streets: _____	Fax: _____
City: _____	

Patient Registration Form

The above is true to the best of my knowledge:

Patient/Guardian Signature: _____



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