



WELCOME TO NORTH SCOTTSDALE PEDIATRICS

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

NICKNAME: _____ SEX: _____ AGE: _____

ADDRESS: _____ HOME PHONE: _____

CELL PHONE (M): _____

_____ CELL PHONE (D): _____

EMAIL: _____ WORK PHONE: _____

RESPONSIBLE PARTIES

MOTHER: _____ DATE OF BIRTH: _____

ADDRESS: _____ EMAIL: _____

_____ SS#: _____

_____ EMPLOYER: _____

FATHER: _____ DATE OF BIRTH: _____

ADDRESS: _____ EMAIL: _____

_____ SS#: _____

_____ EMPLOYER: _____

IN THE EVENT OF AN EMERGENCY, WHO MAY WE CONTACT IF WE ARE UNABLE TO REACH YOU?

NAME: _____ PHONE: _____ RELATIONSHIP: _____

INSURANCE INFORMATION

PCP: _____

PRIMARY INSURANCE CARRIER: _____

CLAIMS ADDRESS: _____

PRIMARY CARD HOLDER: _____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

INSURED ID#: _____ POLICY GROUP #: _____

COPAY: \$ _____ EFFECTIVE DATE: _____

SECONDARY INSURANCE CARRIER: _____

CLAIMS ADDRESS: _____

SECONDARY INS. CARD HOLDER: _____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

INSURED ID#: _____ POLICY GROUP#: _____

COPAY; \$ _____ EFFECTIVE DATE: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED HERE IS TRUE AND CORRECT. I AUTHORIZE NORTH SCOTTSDALE PEDIATRICS TO RELEASE INFORMATION TO MY INSURANCE COMPANY FOR THE PROCESSING OF MEDICAL CLAIMS. I ASSIGN INSURANCE BENEFITS TO NORTH SCOTTSDALE PEDIATRICS FOR ALL MEDICAL SERVICES PERFORMED. I UNDERSTAND THAT INSURANCE BENEFITS ARE DETERMINED BY THE CONTRACT I HOLD WITH MY INSURANCE COMPANY, AND THAT I AM RESPONSIBLE FOR ALL FEES NOT PAID BY INSURANCE AS STATED IN MY POLICY.

SIGNATURE OF GUARANTOR/RESPONSIBLE PARTY

DATE