NORTH SCOTTSDALE
PEDIATRICS
A Division of Arbor Medical Partners

PATIENT INFORMATION

PATIENT NAME:______________________ DATE OF BIRTH:______________

NICKNAME:__________________ SEX:________ AGE:______________

ADDRESS:____________________
____
____

HOME PHONE: ______________
CELL PHONE (M):______________
CELL PHONE (D): ______________
PATIENT CELL:______________

CELL # FOR APPOINTMENT CONFIRMATIONS:__________ CARRIER:____________

PREFERRED LANGUAGE:__________ RACE/ETHNICITY:______________

SIBLINGS AT PRACTICE:____________________________________

RESPONSIBLE PARTIES

MOTHER:____________________ DATE OF BIRTH:______________

ADDRESS:____________________
____
____

EMAIL:______________
SS #: ______________
EMPLOYER: ______________

FATHER: ____________________ DATE OF BIRTH:______________

ADDRESS:____________________
____
____

EMAIL:______________
SS #: ______________
EMPLOYER: ______________

STEPMOM: ____________________ STEPDAD: ______________

****This form does not give consent for step parents to bring children into the office. Please ask the front office for a "Consent To Treat" form to keep on file.****

INSURANCE INFORMATION

DOCTOR'S NAME:____________________

PRIMARY INSURANCE CARRIER: ____

PRIMARY CARD HOLDER: ____

DATE OF BIRTH: ________________ RELATIONSHIP TO PATIENT:____________________

INSURED ID#: ________________ POLICY GROUP #: ____________________

SECONDARY INSURANCE CARRIER: ____

DATE OF BIRTH: ________________ RELATIONSHIP TO PATIENT: ____________________

INSURED ID#: ________________ POLICY GROUP#: ____________________

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. I also hereby certify that the person signing the form will be listed as the Responsible Party (Guarantor) of the Child (ren) accounts. This is who all statements will be sent to.

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Signature of Responsible Party Date