

**North Scottsdale Pediatric Associates, P.C.**  
**10200 N. 92<sup>nd</sup> Street #150**  
**Scottsdale, AZ 85258**  
**(480)860-8488**

*THANK YOU FOR CHOOSING OUR OFFICE! IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION. ALL INFORMATION WILL BE CONFIDENTIAL.*

**PERSONAL INFORMATION**

PATIENT NAME \_\_\_\_\_ SEX \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
REFERRED BY \_\_\_\_\_ ALLERGIES \_\_\_\_\_ DOCTOR \_\_\_\_\_  
SIBLINGS WHO COME TO THIS PRACTICE \_\_\_\_\_

**CONTACT INFORMATION**

FATHER'S NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
CELL PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
CELL PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_

IN THE EVENT OF AN EMERGENCY, WHO MAY WE CONTACT IF WE ARE UNABLE TO REACH YOU?  
NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

**RESPONSIBLE PARTY/LEGAL GUARDIAN**

NAME OF RESPONSIBLE PARENT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_ SS# \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
ADDRESS (IF DIFFERENT FROM PATIENT'S) \_\_\_\_\_

PEOPLE OTHER THAN YOURSELF OR SPOUSE WHO ARE AUTHORIZED TO BRING CHILD IN FOR  
MEDICAL CARE \_\_\_\_\_

**INSURANCE INFORMATION**

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
CARRIER \_\_\_\_\_ ID# \_\_\_\_\_ GROUP # \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

*DOES PATIENT HAVE ADDITIONAL INSURANCE? IF SO, PLEASE COMPLETE THE FOLLOWING:*

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
CARRIER \_\_\_\_\_ ID# \_\_\_\_\_ GROUP # \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**AUTHORIZATION:**

*I hereby authorize North Scottsdale Pediatric Associates, P.C. release any medical information necessary to process medical claims.*  
Signed \_\_\_\_\_ Date \_\_\_\_\_

*I hereby authorize my medical insurance carrier to pay benefits directly to North Scottsdale Pediatric Associates, P.C.*  
Signed \_\_\_\_\_ Date \_\_\_\_\_