



**WELCOME TO NORTH SCOTTSDALE PEDIATRICS
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.

Signature of Responsible Party

Date