



Scottsdale Children's Group

Scottsdale Childrens Group

7555 E Osborn Rd
Scottsdale, AZ 85251
(480) 609-8100

PLEASE USE BLACK INK ONLY

| PATIENT INFORMATION | | | | | | | |
|---------------------------|-----------|-----------------|------------------------|------------------------------------|---------------|---|-----|
| NAME (Last, First Middle) | | | MRN | SSN# | BIRTHDATE | LANGUAGE | SEX |
| LOCAL ADDRESS | | CITY, STATE ZIP | | REFERRING PHYSICIAN | | SECONDARY/BILLING ADDRESS (if Applicable) | |
| HOME PHONE | DAY PHONE | EMAIL ADDRESS | | PRIMARY CARE PROVIDER | | CITY, STATE ZIP | |
| | | | EMERGENCY CONTACT NAME | | CONTACT PHONE | HOME PHONE | |
| PRIMARY EMPLOYER | | | | SECONDARY EMPLOYER (if Applicable) | | | |
| ADDRESS | | | | ADDRESS | | | |
| CITY, STATE ZIP | | | | CITY, STATE ZIP | | | |
| WORK PHONE | | | | WORK PHONE | | | |

| RESPONSIBLE PARTY INFORMATION (if Different than above) | | | | | | |
|---|---|-----------------|----------------|---|------------|-----|
| NAME (Last, First Middle) | | | SSN# | BIRTHDATE | LANGUAGE | SEX |
| LOCAL ADDRESS | | CITY, STATE ZIP | | SECONDARY/BILLING ADDRESS (if Applicable) | | |
| HOME PHONE | DAY PHONE | EMAIL ADDRESS | | CITY, STATE ZIP | | |
| MARITAL STATUS | STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time | SMOKER (Y/N)? | VETERAN (Y/N)? | PRIMARY CARE PROVIDER | HOME PHONE | |
| RELATIONSHIP TO PATIENT | | | | | | |

| PRIMARY INSURANCE | | | |
|------------------------------|-------|------------------|-----------------|
| NAME OF INSURANCE COMPANY | | POLICY# | |
| NAME OF INSURED | | GROUP# | |
| ADDRESS OF INSURANCE COMPANY | | COPAY AMT \$ | |
| CITY, STATE ZIP | PHONE | DEDUCTIBLE \$ | |
| RELATIONSHIP TO PATIENT | | EFFECTIVE DATE | EXPIRATION DATE |

| SECONDARY INSURANCE (if Applicable) | | | |
|-------------------------------------|-------|------------------|-----------------|
| NAME OF INSURANCE COMPANY | | POLICY# | |
| NAME OF INSURED | | GROUP# | |
| ADDRESS OF INSURANCE COMPANY | | COPAY AMT \$ | |
| CITY, STATE ZIP | PHONE | DEDUCTIBLE \$ | |
| RELATIONSHIP TO PATIENT | | EFFECTIVE DATE | EXPIRATION DATE |

Sibling(s)name/DOB _____

I hereby confirm that the above information is true and correct, and that I am the responsible party for this minor. I authorize my insurance benefits to be paid directly to the physician. I agree to pay any and all charges that are patient responsibility. I authorize this clinic or insurance company to release any information required for processing this claim. I also acknowledge receipt of the Scottsdale Children's Group financial policy and that my signature authorizes the above release.

SIGNATURE OF PATIENT/GUARDIAN _____

DATE _____



Name: _____ DOB: _____

Allergies: _____ Date first seen: _____

| NAME | DATE OF BIRTH | HEALTH STATUS | OCCUPATION |
|---------|---------------|---------------|------------|
| Mother | | | |
| Father | | | |
| Sibling | | | |
| Sibling | | | |
| Sibling | | | |

FAMILY HISTORY

Allergy..... Y N Asthma..... Y N Bone / Joint..... Y N
 Cardiac..... Y N Endo / Joint..... Y N Genetic..... Y N
 Hematologic..... Y N Neurologic..... Y N Urinary..... Y N
 Childhood deaths..... Y N Other _____

MEDICAL HISTORY

Medical History: _____

Surgery History (Include age & type of surgery): _____

Hospitalizations (Include age, diagnosis & length of hospitalization): _____

SOCIAL HISTORY

Who does the patient live with: _____
 Does the patient divide time between 2 or more households? _____
 If parents are divorced, what is the custody status? _____
 List all types of pets: _____

BIRTH HISTORY (for patients 0-2 months only)

Name of Obstetrician _____
 How many total pregnancies? _____ • How many live children? _____
 Any difficulties during this pregnancy? Yes No _____
 Any medications taken during this pregnancy? Yes No _____
 Any abnormal lab or ultrasound results? Yes No _____
 Any street drugs or alcohol use during this pregnancy? Yes No _____
 Any medical or mental health issues during this pregnancy? Yes No _____
 Name of hospital: _____ Vaginal or C-Section delivery? _____
 Any complications of labor or delivery? Yes No _____
 Birth Weight _____ lbs _____ oz How long did your baby stay in the hospital? _____
 Did he/she have any medical problems? Yes No _____

Acknowledgment of Receipt of Privacy Notice

Original to be maintained in Patient's permanent medical record

Scottsdale Children's Group

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I acknowledge that I have received a copy of the office's Notice of Privacy Practices for patient:

PATIENT: _____ **DOB:** _____

X

Signature of parent or legal guardian

Date

Printed name of parent or legal guardian

Relationship (parent, legal guardian, personal representative, etc.)

You have the right to review this Notice before signing the acknowledgment authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes. This is valid for 6 years.