



# Scottsdale Children's Group

## Scottsdale Childrens Group

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

### PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS			SECONDARY/BILLING ADDRESS (if Applicable)			
CITY, STATE ZIP		HOME PHONE	CITY, STATE ZIP		HOME PHONE	
PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN		CONTACT NAME		CONTACT 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			SECONDARY/BILLING ADDRESS (if Applicable)		
CITY, STATE ZIP			CITY, STATE ZIP		
HOME PHONE			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		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		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 \_\_\_\_\_