Patient Registration Form

****ONCE THIS FORM IS COMPLETED YOU WILL BE CHECKED IN FOR YOUR APPT.****

PATIENT INFORMATION:

NAME: ______________________________

ADDRESS: ______________________________ **APT#** ______________

CITY: ______________ **STATE:** ______________ **ZIP:** _______-_______

HOME PHONE: ______________ **SEX:** ______________

DOB: ______________ **AGE:** ______________

PEDIATRICIAN: ______________________________

*HOW DID YOU HEAR ABOUT US?*______________________________

RESPONSIBLE PARTY INFORMATION (PARENT / GUARDIAN):

NAME: ______________________________ **Male / Female**

DOB: ______________ **SSN:** ______________

HOME PHONE: ______________ **WORK #:** ______________

ADDRESS: ______________________________ **APT#** ______________

CITY: ______________ **STATE:** ______________ **ZIP:** _______-_______

PRIMARY INSURANCE INFORMATION:

INSURANCE NAME: ______________ **COPAY AMOUNT:** ______________

ID. NUMBER: ______________ **PLAN/GROUP #:** ______________

POLICYHOLDER NAME: ______________ **DOB:** __________ **SSN:** ______________

EMPLOYER: ______________________________

PATIENT RELATIONSHIP TO THE POLICYHOLDER: ______________________________

*****PLEASE PROVIDE OUR OFFICE WITH YOUR CHILD'S CURRENT INSURANCE CARD*****

SECONDARY INSURANCE INFORMATION:

INSURANCE NAME: ______________ **COPAY AMOUNT:** ______________

ID. NUMBER: ______________ **PLAN/GROUP #:** ______________

POLICYHOLDER NAME: ______________ **DOB:** __________ **SSN:** ______________

EMPLOYER: ______________________________

PATIENT RELATIONSHIP TO THE POLICYHOLDER: ______________________________

ADDITIONAL CONTACT INFORMATION:

CELLULAR #: ______________________________

IN CASE OF AN EMERGENCY, CONTACT NAME: ______________ **PHONE #:** ______________

I hereby authorized payment directly to **Scottsdale Children's Group** for surgical and/or medical benefits, if any, otherwise paid to me for unpaid services rendered and the release of any information necessary to process claims for said services and authorization to release records pertaining to my treatment to my insurance company or other 3rd parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan, via voice, electronic, mail or fax transmission. **I UNDERSTAND THAT I AM FINANCIALLY REPONSIBLE FOR MY NON-COVERED SERVICES**. I also agree to pay all charges and/or co payments at the time of service. In the event of default, **I** promise to pay all legal fees, collection costs, and/or interest as may be required for this collection. This will also serve as an authorization for release of emergency department, urgent care and/or medical records, which may be necessary to further my child's medical care.

PARENT / GUARDIAN SIGNATURE: ______________________________ **DATE:** ______________

STAFF SIGNATURE: ______________________________ **DATE:** ______________