PAPAGO BUTTES PEDIATRIC CENTER, A DIVISION OF ARBOR MEDICAL PARTNERS

COMPLETE INFORMATION IS REQUIRED PRIOR TO PHYSICIAN'S EXAMINATION

TODAY'S DATE ______________________________

PRIMARY PHYSICIAN: **S. SOTELO** __________ **S. CANNON** __________ **R. REZNICK** __________ **K. CHELEMEWSKI** __________ **B. WILSON** __________

PATIENT'S INFORMATION

PATIENT'S NAME (FIRST, M.I., LAST)		DATE OF BIRTH	SEX: M_____ F_____
PATIENT'S ADDRESS		CITY, STATE AND ZIP CODE	PATIENT SS# (IF KNOWN)
SIBLING'S NAME (FIRST, M.I., LAST)	SEX: M_____ F_____	DATE OF BIRTH	PRIMARY NUMBER ( )
SIBLING'S NAME (FIRST, M.I., LAST)	SEX: M_____ F_____	DATE OF BIRTH	
EMERGENCY CONTACT		CELL PHONE ( )	WORK PHONE ( )
REFERRED BY	**MARITAL STATUS OF CHILD'S PARENTS (PLEASE CHECK ONE):** **SINGLE** ________ **MARRIED** ________ **DIVORCED** ________		

PARENT'S INFORMATION

MOTHER'S NAME		MOTHER'S DATE OF BIRTH
MOTHER'S SOCIAL SECURITY #		MOTHER'S EMAIL
STREET ADDRESS, CITY, STATE, AND ZIP CODE		MOTHER'S CELL PHONE NUMBER ( )
MOTHER'S EMPLOYER	MOTHER'S OCCUPATION	MOTHER'S WORK PHONE NUMBER ( )
FATHER'S NAME		FATHER'S DATE OF BIRTH
FATHER'S SOCIAL SECURITY #		FATHER'S EMAIL
STREET ADDRESS, CITY, STATE, AND ZIP CODE		FATHER'S CELL PHONE NUMBER ( )
FATHER'S EMPLOYER	FATHER'S OCCUPATION	FATHER'S WORK PHONE NUMBER ( )

INSURANCE INFORMATION

IF YOU DO NOT HAVE A VALID INSURANCE CARD WITH YOU AT TIME OF VISIT YOU WILL BE REQUIRED TO PAY FOR SERVICES ON DATE OF SERVICE.

PRIMARY INSURANCE COMPANY NAME	NAME OF POLICY HOLDER	POLICY NUMBER	GROUP NUMBER
SECONDARY INSURANCE COMPANY NAME	NAME OF POLICY HOLDER	POLICY NUMBER	GROUP NUMBER

I HEREBY AUTHORIZE PAYMENT DIRECTLY FROM MY INSURANCE COMPANY TO THE PHYSICIAN'S OF ARBOR MEDICAL PARTNERS (PAPAGO) FOR MEDICAL TREATMENT(S) PROVIDED TO MY CHILD(REN):

PARENT (GUARDIAN) SIGNATURE ____ DATE: ___________________________

I UNDERSTAND THAT PAYMENT IN FULL OF MY RESPONSIBLE PORTION IS REQUIRED AT THE TIME OF VISIT. IF PBPC, A DIVISION OF ARBOR MEDICAL PARTNERS IS NOT A PROVIDER ON MY INSURANCE, FULL PAYMENT IS DUE ON THE DATE OF SERVICE. IF PBPC IS A PROVIDER ON ON MY INSURANCE, THEN ANY DEDUCTIBLES, COPAYS, OR PERCENTAGES ARE DUE AT THE TIME OF SERVICE. ADDITIONALLY, SHOULD IT BE NECESSARY TO ASSIGN MY ACCOUNT FOR COLLECTIONS, IT IS HEREBY AGREED THAT I SHALL PAY REASONABLE CHARGES, ATTORNEY'S TREATMENT, PAYMENT FEES, AND ALL OTHER COSTS:

PARENT (GUARDIAN) SIGNATURE ____ DATE: ___________________________

I HEREBY AUTHORIZE PBPC A DIVISION OF ARBOR MEDICAL PARTNERS TO EXAMINE AND TREAT MY CHILD(REN) WHEN NECESSARY. I ALSO AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION (PHI), ACQUIRED IN THE COURSE OF EXAMINATION TO CARRY OUT AND HEALTHCAREOPERATIONS (TPO) OF MY CHILD(REN):

PARENT (GUARDIAN) SIGNATURE ____ DATE: ___________________________