PAPAGO BUTTES PEDIATRIC CENTER, P.C.

COMPLETE INFORMATION IS REQUIRED PRIOR TO PHYSICIAN'S EXAMINATION

THANK YOU

PRIMARY PHYSICIAN: REZNICK _____
SOTELO _____
CANNON _____

PATIENT'S INFORMATION

TODAY'S DATE 01/13/17

PATIENT'S NAME (FIRST, M.I., LAST)		DATE OF BIRTH	SEX: M_X_ 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 #		EMAIL ADDRESS
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 #		EMAIL ADDRESS
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	RELATIONSHIP TO PATIENT	INS. ID NUMBER
PREFERRED PHARMACY NAME	LOCATION	PHONE NUMBER	INS. GROUP NUMBER

I HEREBY AUTHORIZE PAYMENT DIRECTLY FROM MY INSURANCE COMPANY TO THE PHYSICIAN'S OF PAPAGO BUTTES PEDIATRIC CENTER 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 PAPAGO BUTTES PEDIATRIC CENTER, P.C. (PBPC) 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 FEES, AND ALL OTHER COSTS:

PARENT (GUARDIAN) SIGNATURE _____ DATE: _____

I HEREBY AUTHORIZE PBPC 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 TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO) OF MY CHILD(REN):

PARENT (GUARDIAN) SIGNATURE _____ DATE: _____