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 _____

PATIENT'S NAME (FIRST, M.I., LAST)		DATE OF BIRTH	SEX: M_____ F_____
PATIENT'S ADDRESS		CITY, STATE AND ZIP CODE	HOME PHONE NUMBER ( )
SIBLING'S NAME (FIRST, M.I., LAST)	SEX: M_____ F_____	DATE OF BIRTH	
SIBLING'S NAME (FIRST, M.I., LAST)	SEX: M_____ F_____	DATE OF BIRTH	
NAME OF NEAREST RELATIVE (**NOT LIVING WITH YOU**)		HOME PHONE ( )	WORK PHONE ( )
REFERRED BY	HAS THIS OFFICE EVER PROVIDED TREATMENT TO A MEMBER OF YOUR FAMILY? **YES**_____, MEMBERS NAME _____ **NO**_____		

MARITAL STATUS OF CHILD'S PARENTS (PLEASE CHECK ONE):

PARENT'S INFORMATION

MARRIED_____ SINGLE_____ SEPARATED_____ DIVORCED_____

MOTHER'S NAME (MAIDEN NAME):		MOTHER'S DATE OF BIRTH
MOTHER'S SOCIAL SECURITY #		MOTHER'S HOME PHONE NUMBER ( )
STREET ADDRESS, CITY, STATE, AND ZIP CODE		MOTHER'S CELL PHONE NUMBER ( )
MOTHER'S EMPLOYER	EMPLOYER'S ADDRESS	MOTHER'S WORK PHONE NUMBER ( )
FATHER'S NAME		FATHER'S DATE OF BIRTH
FATHER'S SOCIAL SECURITY #		FATHER'S HOME PHONE NUMBER ( )
STREET ADDRESS, CITY, STATE, AND ZIP CODE		FATHER'S CELL PHONE NUMBER ( )
FATHER'S EMPLOYER	EMPLOYER'S ADDRESS	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 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 HEALTHCAREOPERATIONS (TPO) OF MY CHILD(REN):

PARENT (GUARDIAN) SIGNATURE _____ DATE: _____