Patient Information Form

Name: ____ **DOB:** _____/_____/_____ **Sex: M or F**

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Address: _______________________________ **City:** __________ **State:** _______ **Zip:** _______

1st Phone: ________________ **2nd Phone:** _________________ **E-mail:** ____________________

Mother Step-Mother Legal Guardian
(Please circle one)
Name: _______________________________

Marital Status: __________ DOB : ____/____/____

SS#: _________________________

Phone # : _______________________

Occupation: _____________________

Father Step-Father Legal Guardian
(Please circle one)
Name: __________________________________

Marital Status: __________ DOB:___/___/_______

SS#: ____________________________

Phone #: __________________________

Occupation: _________________________

Guarantor (person who holds the insurance and is responsible for your account)
Guarantor Name: ____ DOB: ____/_____/_____

Address (if different than above): _________________________ City:________ State:___ Zip: ______

Relationship to Patient (s): _______________Employer:___________________________________

E-mail: ___________________________________ Phone #: ___________________________

Insurance Information:
Primary Insurance: ______________________________ Policy ID #: _______________________
_____ Please initial here if you do not have health insurance

How did you hear about Valley of the Sun Pediatrics: ______________________________

Other siblings not being registered on this form:

Brothers: __________________________ Sisters: _____________________________

Authorization to Pay Benefits to Valley of the Sun Pediatrics:

I hereby authorize Valley of the Sun Pediatrics to release any medical information needed to process insurance claims and authorize payments directly to Valley of the Sun Pediatrics for all medical and surgical benefits. I agree that I am financially responsible on the day of service for any charges not covered by this authorization or not covered by my insurance policy(s).

Parent or Guardian Signature: ________________________________ **Date:** _________________

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