ARIZONA PEDIATRIC SURGERY & UROLOGY, LTD.

PATIENT REGISTRATION FORM

Today's Date _____

PATIENT INFORMATION

Please read carefully and fill out form completely

PATIENT NAME (LAST)	(FIRST)	(MI)	DATE OF BIRTH	☐ MALE ☐ FEMALE

NICKNAME	SOCIAL SECURITY NUMBER	SCHOOL NAME	GRADE

HOME/MAILING ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ( )

PEDIATRICIAN/FAMILY PHYSICIAN NAME	PHONE NUMBER ( )	BEING SEEN FOR

PARENT INFORMATION/RESPONSIBLE PARTY (OR INSURANCE POLICY HOLDER)

☐ FATHER ☐ STEPFATHER ☐ MOTHER ☐ STEPMOTHER ☐ GUARDIAN ☐ FOSTER PARENT ☐ SIBLING ☐ GRANDPARENT

NAME (LAST)	(FIRST)	(MI)	DATE OF BIRTH	SOCIAL SECURITY NUMBER

HOME/MAILING ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ( )

OCCUPATION	EMPLOYER	DRIVER LICENSE NUMBER	CELL PHONE ( )

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE ( )

INSURANCE COMPANY NAME	MEMBER I.D. NUMBER	GROUP NUMBER	CO-PAY	DEDUCTIBLE

CLAIMS ADDRESS	CITY	STATE	ZIP CODE	INSURANCE PHONE ( )

OTHER PARENT / RESPONSIBLE PARTY / (SECONDARY INSURANCE POLICY)

☐ FATHER ☐ STEPFATHER ☐ MOTHER ☐ STEPMOTHER ☐ GUARDIAN ☐ FOSTER PARENT ☐ SIBLING ☐ GRANDPARENT

NAME (LAST)	(FIRST)	(MI)	DATE OF BIRTH	SOCIAL SECURITY NUMBER

HOME/MAILING ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ( )

OCCUPATION	EMPLOYER	DRIVER LICENSE NUMBER	CELL PHONE ( )

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE ( )

INSURANCE COMPANY NAME	MEMBER I.D. NUMBER	GROUP NUMBER	CO-PAY	DEDUCTIBLE

CLAIMS ADDRESS	CITY	STATE	ZIP CODE	INSURANCE PHONE ( )

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS:

The attending physician is authorized to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

I hereby authorize payment of benefits otherwise payable to me directly to Arizona Pediatric Surgery, Ltd., but not to exceed the physician's regular charges for these services. I understand that I am financially responsible to Arizona Pediatric Surgery, Ltd. for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection including reasonable attorney's fees. There will be a $25 collection fee added to all balances sent to collections.

I hereby authorize the attending physician to administer such treatment as is considered necessary on the basis of findings during the course of my examination. I also certify that no guarantee or assurance has been made as to the results which may be obtained.

Please check one: ☐ Parent ☐ Foster Parent ☐ Legal Guardian

Signature of Parent or Guardian:_____ DATE _____

Official Use Only

Account#_____

TMC MRN_____

UMC MRN _____

Dr: _____

ADM: _____

DC: _____

Auth #:_____