

# 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	<input type="checkbox"/> MALE
				<input type="checkbox"/> 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)					
<input type="checkbox"/> FATHER <input type="checkbox"/> STEPFATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> STEPMOTHER <input type="checkbox"/> GUARDIAN <input type="checkbox"/> FOSTER PARENT <input type="checkbox"/> SIBLING <input type="checkbox"/> 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)					
<input type="checkbox"/> FATHER <input type="checkbox"/> STEPFATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> STEPMOTHER <input type="checkbox"/> GUARDIAN <input type="checkbox"/> FOSTER PARENT <input type="checkbox"/> SIBLING <input type="checkbox"/> 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 #: \_\_\_\_\_

