PEDIATRIC MEDICAL ASSOCIATES, P.C.
4824 E. Baseline Road
Building 3, Suite 125
Mesa, AZ 85206

[ ] I [ ] S [ ] WS
[ ] UPDATE

Date: _____ Chart #: _____

FATHER'S Last Name: _____First _____Init____ Home Phone _____

Street Address_____Work Phone _____

City _____State_____ Zip_____ Birth date _____ Soc Sec #_____

Employer _____ Occupation _____ Yrs. Employed _____

Cell Phone _____

MOTHER'S Last Name: _____First _____Init____ Home Phone _____

Street Address_____Work Phone _____

City _____State_____ Zip_____ Birth date _____ Soc Sec # _____

Employer _____Occupation _____Yrs. Employed _____

Cell Phone _____

1) [ ] ***STANDARD INSURANCE INFORMATION:***

NAME of POLICY HOLDER: _____ Effective Date of Coverage_____
NAME OF INSURANCE COMPANY: _____
Claims Mailing Address: _____ City _____State/Zip _____
INSURED'S ID # _____GROUP # _____ DEDUCTIBLE AMT _____ COPAY _____

2) [ ] ***AHCCCS PLAN*: Circle One – APIPA Mercy Care Care First Insert AHCCCS ID# for each child below**

3) [ ] ***NO INSURANCE***

ALL CHILDREN'S NAMES / DATES OF BIRTH	STANDARD INS PLAN NAME / **ID#**	AHCCCS INS PLAN NAME / **ID#**

NEAREST RELATIVE: Name _____Relation _____ Phone _____
Address _____
_____

AUTHORIZATION FOR VERIFICATION OF INFORMATION: I certify that to the best of my knowledge the statements contained herein are true. I authorize PEDIATRIC MEDICAL ASSOCIATES and/or its assignee to verify statements made herein.

RELEASE OF MEDICAL INFORMATION: I authorize the release of any medical information necessary to process claims for insurance reimbursement or payment. I further authorize payment to PEDIATRIC MEDICAL ASSOCIATES of any medical benefits resulting from medical or surgical services rendered by PEDIATRIC MEDICAL ASSOCIATES.

FINANCIAL RESPONSIBILITY: I agree to be responsible for all claims and charges incurred by any of the above named children. I understand that I will be expected to pay for services at the time of each visit, that are required. I further agree to pay all collective costs, responsible attorney fees, and other costs that may be incurred to enforce collection of any amounts outstanding.

FOR EMERGENCY CARE: I authorize the performance of any necessary medical and surgical treatment of my children in case of illness or accident when neither parent (nor guardian) can be located. The medical and surgical services required may be performed by the physicians of PEDIATRIC MEDICAL ASSOCIATES or a licensed physician of their choice, at the medical facility, office, emergency room or hospital of their choice.

SIGNATURE _____ DATE _____
Parent/Guardian