



### PATIENT INITIAL DEMOGRAPHICS

Patient Name: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

**Race:** (check all that apply)

- White
- Native Hawaiian/Pacific Islander
- Asian
- American Indian/Alaska Native
- Black/African America

**Ethnicity:**

- Hispanic/Latino
- Non Hispanic/Latino
- Declined to Report

**Language:** (Primary)

- English
- Spanish

**MOTHER    STEP-MOTHER    LEGAL GUARDIAN    (Please circle one)    FATHER    STEP-FATHER    LEGAL GUARDIAN**

Name: \_\_\_\_\_

Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Work #: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS#: \_\_\_\_\_

Employer: \_\_\_\_\_

Name: \_\_\_\_\_

Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Work #: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS#: \_\_\_\_\_

Employer: \_\_\_\_\_

If patient lives at two different addresses, please provide. This address is:  Mother's  Father's  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Whom can we contact in case of emergency AND if necessary release protected health information?  
Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone#: \_\_\_\_\_

**Primary Insurance Information:** *(Insurance card required at time of appointment)*

Name of Insurance Company: \_\_\_\_\_

Policy # or AHCCCS #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

**Secondary Insurance Information:** *(Insurance card required at time of appointment)*

Name of Insurance Company: \_\_\_\_\_

Policy # or AHCCCS #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

**Consent to Treat and Responsibility Statement** – I, acting as guardian of the above patient, hereby give consent for the patient to receive medical evaluation and treatment by providers at Yavapai Pediatrics. I have received a copy of the Privacy Rules from Yavapai Pediatrics and authorize the above named people to receive my child's Protected Health Information. I assign all benefits and payments from my insurance company to be paid directly to Yavapai Pediatrics. I understand that if for any reason my insurance does not make payments, I am responsible for all services. I accept responsibility for co-pays, deductibles, co-insurance, and any other balances not paid by the insurance. I authorize the release of all medical information necessary to process this claim and pertinent to my child's medical care and related benefits. This assignment will remain in effect until revoked by me in writing. A photocopy or facsimile of this assignment is considered to be as valid as the original. I also understand that by signing below, I authorize use of the above named patient's personal health information to be used for providing necessary treatment, payment, and other healthcare operations. Any other use of this information will require a separate release authorizing such use. A signature is necessary for us to process insurance claims and to ensure payment for services rendered.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness Initials \_\_\_\_\_