PATIENT INITIAL DEMOGRAPHICS

Patient Name: _____ ☐ Male ☐ Female Date of Birth: ____/____ /____

Mailing Address: _____

Physical Address: _____

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, herby 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 _____