

**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**

<u>ALL CHILDREN'S NAMES / DATES OF BIRTH</u>	<u>STANDARD INS PLAN NAME / ID#</u>	<u>AHCCCS INS PLAN NAME / ID#</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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*