PLEASE FILL OUT FORM IN ITS ENTIRETY ****BLACK INK ONLY****

Child

Name:_____ Birth Date:___/___/___ Sex:_____ Age:_____

Social Security #: ____/___/____ Race: _____ Ethnicity: _____ Preferred Language: _____

Child lives with: _____Mother _____Father _____ Other

Pharmacy: _____ Location: _____ Phone: (____) _____

Siblings	Birth Date	Sex	Age
1. _____	____/____/____	M / F	_____
2. _____	____/____/____	M / F	_____
3. _____	____/____/____	M / F	_____
4. _____	____/____/____	M / F	_____

Parent/ Guardian

Last Name: _____ First Name: _____ Home Phone: (____) _____

Home Address: _____ Apt #:_____ Cell Phone: (____) _____

City: _____ State: _____ Zip Code: _____

Birth Date:____/___/____ Sex: M / F Marital Status: _____Social Security #: _____/_____/_____

Email Address: _____

Billing address (if different than home)

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Employer Phone #: (____) _____

Parent/ Guardian

Last Name: _____ First Name: _____ Home Phone: (____) _____

Home Address: _____ Apt #:_____ Cell Phone: (____) _____

City: _____ State: _____ Zip Code: _____

Birth Date:____/___/____ Sex: M / F Marital Status: _____Social Security # _____/_____/_____

Email Address: _____

Billing address (if different than home)

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Employer Phone #: (____) _____

Person to contact in case of emergency other than Parents:

Name: _____ Phone #: (____) _____ Relationship: _____

Insurance Information

Primary Insurance: _____ Employer: _____

Insured Name: _____ Date of Birth: ____/____/____ Relationship: _____

Insured's Address (if different than patient)

Street: _____ City: _____ State: _____ Zip Code: _____

Insurance I.D.#: _____ Group: _____

Secondary Insurance: _____ Employer: _____

Insured Name: _____ Date of Birth: ____/____/____ Relationship: _____

Insured's Address (if different than patient)

Street: _____ City: _____ State: _____ Zip Code: _____

Insurance I.D.#: _____ Group: _____

I hereby authorize Phoenix Children's Center, Ltd to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. In the event that payment is not made on this account and it is placed with a licensed collection agency, I/we agree to pay the fees of the collection agency equal to a maximum of 50% of our outstanding balance at the time the account is placed with the agency. Interest of 10% per year will be accrued on the principal balance. Should legal action also be necessary to collect the account, I/we agree to pay attorney's fee and court costs incurred for collection. Once your account is placed in collection our office can no longer provide medical care for your child/children.

Insured Signature:

X:_____ Date: ____/____/____

Signature of parent or guardian if patient is a minor:

X: _____ Date: ____/____/____