**Date:________________**

Wendy Rocha Saucedo, MD
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# Patient Information Form

Thank you for choosing Arizona Pediatrics for your child's medical care.
Please take a few minutes to fill out the front and back of this information form completely.

## PATIENT INFORMATION

Patients Name:____________________________________________ Date of Birth_______________________________

Social Security Number:______________________________ Gender: Male______ Female_______ Age______________

Patient lives with: Mother_______ Father_______ Both ________Other_____

Address:__________________________________________________________________________________________
**(apt#) (City) (State) (Zip Code)**

Home Phone:___________________________________ Other Phone:___________________________________

## PARENT'S INFORMATION

**Mother's Name**:________________________________

Social Security Number:_____________ Date of Birth:_____

Address:________________________________________

_______________________________________________

Employer Name___________________________________

Address:________________________________________

_______________________________________________

Phone:_________________________________________

**Father's Name**:__________________________________

Social Security Number:_____________ Date of Birth:_____

Address:________________________________________

_____________________________________________

Employer Name_________________________________

Address:________________________________________

_____________________________________________

Phone:_________________________________________

## EMERGENCY CONTACT

Name_________________________________________ Phone:_(_____)__________________________________

Address_______________________________________ Relationship:_____________________________________

## INSURANCE INFORMATION

Primary Insurance Name:____________________________

Address:________________________________________

Phone:_________________________________________

Policy Holder:____________________________________

Secondary Insurance Name:_________________________

Address:________________________________________

Phone:_______________________________________

Policy Holder:__________________________________

Policy Holder Date of Birth:______________________________

Relationship to patient:__________________________________

Policy #:_______________________________________________

Group #:_______________________________________________

Policy Holder Date of Birth:___________________________

Relationship to patient:______________________________

Policy #:__________________________________________

Group #:__________________________________________

## AGREEMENT TO PAY FOR TREATMENT AND RELEASE OF INFORMATION

I hereby authorize direct payment to be made to Arizona Pediatrics. I understand that Arizona Pediatrics will file an insurance claim on my behalf as a courtesy, nevertheless, I am financially responsible for any charge or service not covered by my insurance company. By signing below I certify that all data provided is accurate including insurance information.

_______________________________________________________ _______________________________________________________

Signature of Parent/Legal Guardian Date

I authorize the release of medical information necessary to process insurance claims

_______________________________________________________ _______________________________________________________

Signature of Parent/Legal Guardian Date

**WE ARE REQUIRED BY LAW TO HAVE A COPY OF YOUR INSURANCE CARD**