OLD PUEBLO PEDIATRICS

3043 W. Ina Road ● Tucson, Arizona 85741
Phone: (520) 797-7070 ● Fax: (520) 797-7077

Please clearly print all information

PATIENT INFORMATION:

Name: _____ _____ _____
Last First Middle DOB Sex (M / F)

_____ _____ _____
Street Address City, State Zip Code

Home Phone # _____ How did you hear about Old Pueblo Pediatrics? _____

With whom does the child reside? (Please circle) Parents / Mother / Father / Step-Parent / Guardian / Foster

Please note: If you are not the parent, please provide guardianship documentation.

PARENT INFORMATION:

Mother / Step-Parent / Guardian / Foster *(Please Circle)*

Name: _____ _____ _____
Last First Middle DOB SS #

_____ _____ _____
Street Address City, State Zip Code

Employer: _____ _____ _____
Work Phone # Cell / Other #

E-Mail Address: _____

Father / Step-Parent / Guardian / Foster *(Please Circle)*

Name: _____ _____ _____
Last First Middle DOB SS #

_____ _____ _____
Street Address City, State Zip Code

Employer: _____ _____ _____
Work Phone # Cell / Other #

E-Mail Address: _____

INSURANCE INFORMATION:

Primary Insurance

Name _____ ID # _____ Group # _____
Address _____ Policy Holder's Name _____
Phone # _____ Policy Holder's DOB _____
Effective Date _____ Policy Holder's SS # _____

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to Old Pueblo Pediatrics, PLLC. I understand that I am financially responsible for any non-covered services. Furthermore, I authorize Old Pueblo Pediatrics, PLLC to release any necessary information to my insurance carrier in order to process this claim. I have read and agree to the terms of payment for Old Pueblo Pediatrics.

_____ _____ _____ _____
Signature Printed Name Relationship to Patient Date

_____ I have received and reviewed the Notice of Privacy Practices.

Authorization for Medical Treatment

Please clearly print all information

PATIENT INFORMATION:

Name: _____ _____ M / F

Last First Middle DOB Sex

_____ _____ _____

Street Address City, State Zip Code

In my absence, the following person(s) have my authorization to seek medical attention and/or provide signed written consent for immunizations and/or procedures regarding my above mentioned child.

Please note: If there are custody issues we need to be aware of, legal documentation must be provided.

Name	Relationship to Patient	Contact's Phone Number
Name	Relationship to Patient	Contact's Phone Number
Name	Relationship to Patient	Contact's Phone Number
Name	Relationship to Patient	Contact's Phone Number

Signature	Printed Name	Relationship to Patient	Date

This authorization will automatically expire in one year from signature date or we receive written documentation stating otherwise.

EMERGENCY CONTACT:

Name: _____ _____

Last First Middle Relationship to Patient

_____ _____ _____

Home Phone Number Work Phone Number Cell Phone / Other Number

Name: _____ _____

Last First Middle Relationship to Patient

_____ _____ _____

Home Phone Number Work Phone Number Cell Phone / Other Number