PARADISE PEDIATRICS
FAMILY INFORMATION UPDATE
All information is required either by your insurance carrier or by the State of Arizona.

New Patient Name:	**DOB:**	**Physician:**

Parent/Guardian Information:

Father's/Guardian Name:_____ Birthdate:_____
Address:_____ City_____ State____ Zip____
Hm Phone:(____)_____ Wk Phone:(____)_____
Cell Phone:(____)_____ Pager#:(____)_____
Social Security#:_____

Mother's/Guardian Name:_____ Birthdate:_____
Mother's Maiden Name:_____
Address:_____ City_____ State____ Zip____
Hm Phone:(____)_____ Wk Phone:(____)_____
Cell Phone: (____)_____ Pager#:(____)_____
Social Security#:_____

***Primary Insurance Information*: (Need Copy of Ins Card)**

Cardholder Name:_____ ID#:_____
Group#_____ Copay:_____ Effective Date:_____
DOB of Cardholder:_____ Employer:_____
Ins. Co. Name_____ Phone#:(____)_____
Address for Claims:_____

***Secondary Insurance Information*:(Need copy of Ins Card)**

Cardholder Name:_____ ID#:_____
Group#:_____ Copay:_____ Effective Date:_____
DOB of Cardholder:_____ Employer:_____
Ins. Co. Name:_____ Phone#:(____)_____
Address for Claims:_____

Active Children	**DOB**	**Gender**	**Physician**	**Suffix#**
		M or F		
		M or F		
		M or F		
		M or F		

I certify that my dependent (s) have insurance coverage as indicated above and assign directly to Paradise Pediatrics, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance as well as knowing what my benefits are. I hereby authorize the use of this signature on all insurance submissions as well as to release information necessary for the payment of claims. I understand that I am responsible for any and all amounts not covered by insurance. In the event of default, I will be responsible for any collection cost(s) and reasonable attorney fees as maybe required to affect collection of this account.

_____ _____
Date Signed Signature

PP UpdateFrm 9/07

Front Desk Initials_____