PARADISE PEDIATRICS
FAMILY INFORMATION

All information is required either by your insurance carrier or by the State of Arizona

Patient Name:	DOB:	PHYSICIAN

Parent/Guardian Information:

Mother's/Guardian Name: Birthdate:
Mother's Maiden Name:
Address: City State Zip code
Home Phone ( ) Work Phone
Cell Phone ( ) Pager#
Social Security#:

Father's/Guardian Name: Birthdate:
Address: City State Zip code
Home Phone ( ) Work 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 Company 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 Company Name______________________ Phone #______________________
Address for claims______________________

Children's' Names	DOB	Gender	Physician
		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______________________
Father's or Guardian Signature______________________________________

Date Signed______________________
Mother's or Guardian Signature______________________________________