DESERT PEDIATRICS

MEMBER OF ARIZONA COMMUNITY PHYSICIANS

MRN _____

Date _____

PATIENT REGISTRATION FORM

Patient Information

Last Name	First Name	Middle	Date of Birth

Sex	Marital Status	Student	Primary Care Physician

Address/Street	City	State	Zip

Primary Phone number/Relationship	Secondary Phone Number/Relationship

Emergency Contact	Name	Phone	Relationship

Billing Information

First Name	Last Name	Mailing Address	Phone

Primary Insurance

Insurance Name	Claims Address	
Group Number	**ID/Policy Number**	**Co-Pay**
Subscriber Name	**Date of Birth**	**Effective Date**

Patient's Relationship to Subscriber

☐ Self ☐ Child ☐ Foster Child ☐ Step Child ☐ Spouse

Secondary Insurance

Insurance Name	Claims Address	
Group Number	**ID/Policy Number**	**Co-Pay**
Subscriber Name	**Date of Birth**	**Effective Date**

Patient's Relationship to Subscriber

☐ Self ☐ Child ☐ Foster Child ☐ Step Child ☐ Spouse

By signing this form, I herby authorize and request payment of medical benefits for services and/or supplies rendered to me be paid directly to ARIZONA COMMUNITY PHYSICANS, P.C. or the authorized representitive. I authorize release of any medical record or other information necessary to process claims, related to such services, to government benefit programs or other medical insurance payers. I further permit a copy of this authorization to be used in place of the original. By signing, I understand regaurdless of any available insurance plane or program, I am financially responsible for any incured charges.

The effective period of this authorization is from toda's date to a future date, when I am no longer a patient of the Arizona Community Physicians, P.C. group or deceased.

Patient or Gaurdian Signature: _____