*Pullman & Ariza Pediatrics*

*Page 1: Insurance/Financial Information – Please Print*

| PATIENT INFORMATION | | | Today's Date (Month, Day, Year) | | Account # |
|---|---|---|---|---|---|
| Patient Last Name | | | Patient First Name | | Patient Middle Name |
| Gender | Date of Birth (Month, Day, Year) | | Age | Patient Social Security # | |
| Street Address | | | | City, State, Zip | Apt # |
| Home Phone # | Mobile Phone # | Work Phone # | Other Phone # | Please Tell Us Who Referred You: | |

| SIBLINGS WE MIGHT HAVE SEEN IN THIS OFFICE | | | | |
|---|---|---|---|---|
| First Name: | Middle Initial: | Last Name: | Age: | Gender: |
| | | | | |
| | | | | |
| | | | | |

| GUARANTOR/FINANCIALLY RESPONSIBLE PARTY | | | |
|---|---|---|---|
| Guarantor's Last Name | | Guarantor's First Name MI | Home Phone # |
| Address | Apt # | City, State, Zip | Work Phone # |
| Employer | | Employer's Address | |

| PRIMARY INSURANCE INFORMATION | | | |
|---|---|---|---|
| Insurance Company | ID # | | Group # |
| Address | City, State, Zip | | Phone # |
| Policy Holder's Name | Policy Holder Date of Birth | | Social Security # |
| Policy Holder's Employer | Patient's Rel. to Ins. | Visit Copayment | Insurance Effective Date |

| SECONDARY INSURANCE INFORMATION | | | |
|---|---|---|---|
| Insurance Company | ID # | | Group # |
| Address | City, State, Zip | | Phone # |
| Policy Holder's Name | Policy Holder Date of Birth | | Social Security # |
| Policy Holder's Employer | Patient's Rel. to Ins. | Visit Copayment | Insurance Effective Date |

| AUTHORIZED PERSON TO CONTACT FOR BILLING OR RESULTS | | | |
|---|---|---|---|
| Name | Phone # | Name 2 | Phone # |

**1. Financial Responsibility**

I certify that the information I have provided regarding my insurance coverage is correct and authorize Pullman & Ariza to verify insurance coverage and benefits allowed in accordance with my insurance plan's policies.
I authorize that payments be made directly to Pullman & Ariza for all medical insurance benefits which are payable under the terms of my insurance policy for services provided.

I agree to pay any copayment, coinsurances, or deductible as required by my insurance plan for medical care provided to me or my dependent.

I agree to accept full responsibility for payment if my insurance coverage is not verified.

**2. Release of Medical Information For Billing**

I hereby authorize Pullman & Ariza to submit a claim and a copy of medical records related to such services to my payor for medical services provided to me or my dependent.

**3. Receipt of Privacy Notice**

I have been given the opportunity to review Pullman & Ariza's Notice of Privacy Practices which provides a detailed description of how my Protected Health Information (PHI) is used and disclosed.

**4. Non-Covered Services**

I agree to pay for medical services provided to me or my dependent which are not covered by the benefits in my insurance plan.

| I Agree to the Above Stated Responsibility and Consent | |
|---|---|
| Signature of Patient or Legal Guardian | Date |

## *Pullman & Ariza Pediatrics*

### *Page 2: Demographic/Contact Information – Please Print*

| PARENT / GUARDIAN 1 | | | | |
|---|---|---|---|---|
| Last Name | First Name MI | | Relationship to Patient | Social Security # |
| Occupation | Work Address | | City, State, Zip | |
| Home Phone # | Work Phone # | | Mobile Phone # | |
| Email Address | | | | |
| Signature of Parent / Guardian 1 | Printed Name | | Date | |

| PARENT / GUARDIAN 2 | | | | |
|---|---|---|---|---|
| Last Name | First Name MI | | Relationship to Patient | Social Security # |
| Occupation | Work Address | | City, State, Zip | |
| Home Phone # | Work Phone # | | Mobile Phone # | |
| Email Address | | | | |
| Signature of Parent / Guardian 2 | Printed Name | | Date | |

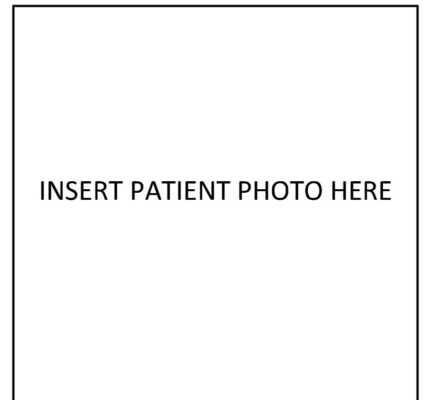
| ADDITIONAL PEOPLE AUTHORIZED TO BRING PATIENT TO APPOINTMENTS | | | |
|---|---|---|---|
| Last Name | First Name MI | Relationship to Patient | Date |
| Phone # | Authorized to sign for vaccines ☐ Yes ☐ No | | Guardian Initial Here |
| Last Name | First Name MI | Relationship to Patient | Date |
| Phone # | Authorized to sign for vaccines ☐ Yes ☐ No | | Guardian Initial Here |
| Last Name | First Name MI | Relationship to Patient | Date |
| Phone # | Authorized to sign for vaccines ☐ Yes ☐ No | | Guardian Initial Here |
| Last Name | First Name MI | Relationship to Patient | Date |
| Phone # | Authorized to sign for vaccines ☐ Yes ☐ No | | Guardian Initial Here |
| Signature of Parent / Guardian | Printed Name | Date | |

**Consent to Leave Phone Messages**

I understand that as part of my health care and treatment, Pullman and Ariza Pediatrics (P&A) may need to reach me by phone. P&A will provide a confirmation call to remind you of your upcoming appointment.

☐ **I DO** authorize P&A to leave a message on my voicemail/answering machine(s) regarding communication of my health care/treatment such as appointment reminders, lab results, consultations and/or billing needs. Preferred contact number(s): ________________________________________.

☐ **I DO NOT** authorize P&A to leave a message on my home, cell, or work phone regarding communication of my health care/treatment such as appointment reminders, lab results, consultations and/or billing needs. **I understand that selecting this option may result in delayed communication of pertinent treatment information such as appointment reminders, lab results, consultations and/or billing needs. I understand that I will be responsible to make appointments to obtain this information.**



**Patient Questionnaire**

Knowledge of family histories of certain illnesses may assist us in evaluating sicknesses in your child. We appreciate your time and care in providing us with this (privileged) information. As needed by you or your doctor, the family history may be discussed or further calculated.

Thank you for your assistance.

A. Please indicate below the age and general health of this child's mother, father, and any sisters or brothers.

Parent 1

Parent 2

Siblings

B. Please indicate in the space below whether your child's blood relatives have ever had any of the following illnesses.

| Illness | Yes | No | Relationship to Your Child |
|---|---|---|---|
| 1. Asthma | ☐ | ☐ | |
| 2. Hay Fever | ☐ | ☐ | |
| 3. Allergies (Medicine, Food, Pollens) | ☐ | ☐ | |
| 4. Heart Trouble | ☐ | ☐ | |
| 5. High Blood Pressure | ☐ | ☐ | |
| 6. Anemia (Low Iron) | ☐ | ☐ | |
| 7. Sickle Cell | ☐ | ☐ | |
| 8. Cancer or Leukemia | ☐ | ☐ | |
| 9. Birth Defects | ☐ | ☐ | |
| 10. Diabetes | ☐ | ☐ | |
| 11. Thyroid Disease | ☐ | ☐ | |
| 12. Eye or Ear Disorders | ☐ | ☐ | |
| 13. Intellectual Disability | ☐ | ☐ | |
| 14. Tuberculosis | ☐ | ☐ | |
| 15. Hepatitis or Yellow Jaundice | ☐ | ☐ | |
| 16. Kidney Disease | ☐ | ☐ | |
| 17. Epilepsy | ☐ | ☐ | |
| 18. Psychiatric Condition | ☐ | ☐ | |
| 19. Venereal Disease | ☐ | ☐ | |
| 20. Serious Child Illness or Death | ☐ | ☐ | |
| ○ Other (Specify) | | | |
| | | | |
| | | | |
| | | | |