CHANDLER PEDIATRICS - Patient Information

□ Dr. C Riordan □ Dr. I Malkani □ Dr. V. Kamerkar

Name: _____ Sex: M F Date of Birth: _____

Address: _____ City: _____ State: ____ Zip _____

Child's SS#: _____- _____ - _____

Father's Name: _____DOB: / / Mother's Name: _____DOB: / /

Address: _____ Address: _____

City: _____ State: _____ City: _____ State: _____

Home: Phone: _____ Home Phone: _____

Cell/Business Phone: _____ Cell/Business: _____

E-Mail Address: _____

Siblings: _____

Any known allergies**:** _____

Pharmacy: _____ Location: _____

Emergency Contact (not in same household): _____

Phone #: _____ Relationship to Patient: _____

Insurance Information:

Type of Insurance: _____ Policy Holder: _____

Patient ID #: _____ Group #: _____

Preferred Language: □ English □ Other _____

Race: □ American Indian/Alaska Native □ Black/African American □ Asian
□ Native Hawaiian or other Pacific Islander □ White

Ethnicity: □ Hispanic □ Latino □ Non-Hispanic □ Non-Latino

Insurance Authorization and Assignment:

I hereby authorize the physicians affiliated and practicing with Chandler Pediatrics to furnish any pertinent information to insurance carriers concerning any illness and treatments and I hereby assign to Chandler Pediatrics all payments for services rendered to myself or my dependants. I understand that I am responsible for any services of portion thereof not covered by my insurance.

Date Signed: _____ **Signature**: _____