CHANDLER PEDIATRICS

Patient Information

□ **Dr. C. Riordan** □ **Dr. I Malkani** □ **Dr. A. McCoy**

Patient's Name: _____ Sex: M F Date of Birth: _____

Address: _____ City: _____ State: ___ Zip: _____

Father/Mother: _____ DOB: _____ Phone: _____

Father/Mother: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

☐ ***(Check if one parent's address if different from child)***

E-Mail Address: _____

Siblings: _____

Known Allergies: _____

Pharmacy: _____ **Location**: _____

Emergency Contact/ not in same household: _____

Phone #: _____ Relationship to patient: _____

Insurance Information:

Name of Insurance Company: _____

Policy Holder: _____

Patient ID #_____ Group ID #: _____

Preferred Language: ☐ English ☐ Other _____

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ American Indian ☐ Asian ☐ Other

Ethnicity: (Ex. American Indian, French, Irish, etc.) _____

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: _____ **Signature**: _____