Initial Demographics

Patient Information -*Thank you for choosing our office. In order to serve you properly and accurately bill your insurance company, we need the following information. Please print. All information is kept confidential.*

Child's Name_____ Date of Birth_____
**if child has ever used another last name, please provide*

Physical Address_____ Home Phone_____

City, State, Zip code_____ Cell Phone_____

Mailing Address_____ Work Phone _____

Guardian/Legal Caregivers_____ *Email_____

Relationship to Child_____ Preferred Pharmacy_____

May we leave messages on identifiable answering system regarding appointment/lab results? Y N **Initials**_____

Whom can we contact in case of emergency AND leave protected health information?

Name_____ Phone_____

I have received a copy of the Privacy Rules from Cornerstone Pediatrics and authorize the above named people to receive my child's Protected Health Information. I may revoke this at any time by giving written notification to Cornerstone Pediatrics.

Signature_____ **Date**_____

***Race**

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other Race

***Ethnicity**

- Hispanic or Latino
- Not Hispanic or Latino

Primary Insurance Information– *Insurance card required at time of appointment.*

Name of Insurance company (network)_____

Policy # or AHCCCS #_____ Group #_____

Name of Insured (not child)_____ Relationship to Child_____

Insured's Social Security #_____ Insured's Date of Birth_____

Secondary Insurance Information- *Insurance card required at time of appointment.*

Name of Insurance company (network)_____

Policy # or AHCCCS #_____ Group #_____

Name of Insured (not child)_____ Relationship to Child_____

Insured's Social Security #_____ Insured's Date of Birth_____

Responsibility Statement -Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. It is your responsibility to pay co-pays, deductibles, co-insurance, and any other balances not paid by your insurance. ***We will assist you in receiving reimbursement, but you are still responsible for your bill. I agree to be financially responsible for all charges. I have read this information and understand it.*** I authorize the release of all medical information necessary to process this claim and that is pertinent to my child's medical care and related benefits. I authorize payment of all insurance benefits to Cornerstone Pediatrics, P. C. This assignment will remain in effect until revoked by me in writing. A photocopy or facsimile of this assignment is considered to be as valid as the original. I also understand that by signing below, I authorize use of the above named patient's personal health information to be used for providing necessary treatment, payment, and other healthcare operations. Any other use of this information will require a separate release authorizing such use.Your signature is necessary for us to process insurance claims and to ensure payment for services rendered.

_____ _____

Parent / Legal Guardian **Date** **Witness Initial**

**Government Requirement*