

Children's Medical Center of Tucson

Patient information Sheet

Please note in order to keep Current information on patients, we ask that this form be updated every 6 months; or when changes occur.

First Name: _____ Last Name: _____ Middle Name _____ Girl/Boy
Date of Birth: ____/____/____ SS#: _____ Birth Weight: _____
Mother/ Guardian: _____ SS#: _____ DOB: ____/____/____
Employer: _____ Work Phone #: _____
Father/Guardian: _____ SS#: _____ DOB: ____/____/____
Employer: _____ Work Phone #: (____) _____
Home Address: _____
City: _____ State: _____ Zip: _____
Mailing Address (if different than above) _____
Home Phone: (____) _____ Cell Phone: (____) _____ Email address: _____
Do you give Children's Medical Center Permission to leave a message on your home phone? _____
Name of the nearest relative not living with you?: _____ Phone #: (____) _____
Whom may we contact in case of an emergency?: _____ Phone #: (____) _____
Who is financially responsible for the bill?: _____
**Who is authorized to bring in the child for medical evaluation in your absence?
Name: _____ Relation to Patient: _____
Name: _____ Relation to Patient: _____
Name: _____ Relation to Patient: _____

****WE WILL REQUIRE IDENTIFICATION****

Primary Insurance Information

Insurance Company Name: _____
Identification #: _____ Group #: _____ Copay: \$ _____
Policy Holder's Name: _____ DOB: ____/____/____
Policy Holder's Employer: _____ Phone #: (____) _____

Secondary Insurance Information

Insurance Company Name: _____
Identification #: _____ Group #: _____ Copay: \$ _____
Policy Holder's Name: _____ DOB: ____/____/____
Policy Holder's Employer: _____ Phone #: (____) _____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for professional services rendered. I have read all the information on both sides of this sheet and have completed the above questions. I certify that all the information I have provided is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance status or the above information. I have also read and received a copy of the Notice of Privacy Practices.

Signature of Parent: _____ Date: _____

Name of other children that are presently patients here

rec _____ ent _____

PLEASE SEE BACK

revised 11/02/07