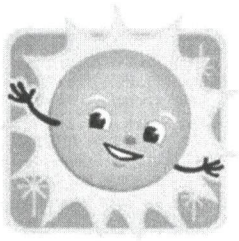

Chandler Pediatrics
1850 W. Frye Rd Suite 102
Chandler, AZ 85224

Child's Full Name: _____
First M Last
Date of Birth: _____ Sex: [ ] Male [ ] Female

Address: _____City_____
State: _____ ZIP: _____ Phone: ( ) _____
Child resides with: [ ] both parents [ ] mother [ ] father [ ] other _____

Mother's Name: _____ Date of Birth: _____

SS #: _____Cell Phone: ( ) _____

Employer: _____

Wk. Phone: ( ) _____ Home Phone: ( ) _____

Email: _____

Preferred method to contact you or leave messages: [ ] Cell or [ ] email

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Father's Name: _____ Date of Birth: _____

SS #: _____Cell Phone: ( ) _____

Employer: _____

Wk. Phone: ( ) _____ Home Phone: ( ) _____

Email: _____

Preferred method to contact you to confirm appointments: [ ] Cell or [ ] email

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Is it okay to leave lab result on phone [ ] yes [ ] No Phone #: ( ) _____

Primary Insurance Information:

Insurance Company Name: _____

Phone Number: _____ ID #:_____

Group #:_____ Policy holders name: _____

SS#:_____ D.O.B._____ Relation: _____

Secondary Insurance Information:

Insurance Company Name: _____

Phone Number: _____ ID #:_____

Group #:_____ Policy holders name: _____

SS#:_____ D.O.B._____ Relation: _____

Emergency Contact (other than parent):

Name: _____Relationship:_____

Phone: ( ) _____ Cell Phone: ( ) _____

Pharmacy Information:

Does Chandler Pediatrics have consent to e - prescribe medication? [ ] Yes [ ]No

Name of Pharmacy: _____

Phone: _____Cross Streets: _____

How did you hear about Chandler Pediatrics?_____

CONSENT TO TREAT/PRIVACY POLICY ACKNOWLEDGEMENT:

I, acting as a guardian to the above named patient, hereby give my consent for the above patient to receive medical evaluation and treatment by the provider's at Chandler Pediatrics. I acknowledged that I may obtain The Notice Of Privacy Policy: (located at the front desk)

Signature: _____ Date: _____