Step By Step Pediatrics, P.C.
5680 W Chandler Blvd Suite 3 Chandler AZ 85226

PATIENT INFORMATION		
Patient Name:	Gender:	DOB:
Patient Name:	Gender:	DOB:
Patient Name:	Gender:	DOB:
Patient Name:	Gender:	DOB:
Address: City, State, Zip:	Home Phone: Cell Phone:	

INSURANCE INFORMATION **Please give ID and all insurance cards to the front office**	
Primary Insurance:	**Secondary Insurance**:
Policy Subscriber Name:	Policy Subscriber Name:

PARENT/LEGAL GUARDIAN	PARENT/LEGAL GUARDIAN
Parent/Legal Guardian Name:	Parent/Legal Guardian Name:
Address: (If different than pt)	Address: (If different than pt)
DOB:	DOB:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email address:	Email address:
Employer/Profession:	Employer/Profession:

EMERGENCY CONTACT OTHER THAN PARENTS/GUARDIANS		
In an emergency notify:		Relation:
Home Phone:	Work Phone:	Cell Phone:

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

ALL COPAYMENT, COINSURANCE AND DEDUCTIBLE AMOUNTS ARE DUE AT THE TIME SERVICE IS RENDERED.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I hereby authorize Step By Step Pediatrics to provide such medical services, either regular or emergency, as may be determined by the physician to be in the best interest (or the best interest of my dependent if I am signing as a parent or guardian). I also hereby authorize Step By Step Pediatrics to furnish information to insurance carriers concerning my medical condition and treatments. I hereby assign to the physician all payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for any and all amounts not covered by insurance. In the event of default, I promise to pay collection costs and reasonable attorney fees as may be required to effect collection of this account.

Signature of Patient/Parent/Guardian: _____ Date: _____