Patient Name: _____

APNNA
Arizona Pediatric Neurology & Neurogenetics Associates, PLLC
Registration Information

PATIENT INFORMATION:

Patient Name LAST FIRST MIDDLE	Date of Birth Gender M F
STREET APT.	Patient's Social Security Number
CITY STATE ZIP	HOME PHONE NUMBER

PARENT INFORMATION (if foster care parent, please complete Guardian Section):

Parents' Marital Status SINGLE ____ MARRIED ____ PARTNERED ____ SEPARATED ____ DIVORCED ____ WIDOWED ____			
Mother's Name LAST FIRST MIDDLE		Father's Name LAST FIRST MIDDLE	
Mother's Date of Birth	Mother's Social Security No.	Father's Date of Birth	Father's Social Security No.
Mother's Address (if different from Patient's)		Father's Address (if different from Patient's)	
Mother's Phone Numbers HOME WORK		Father's Phone Numbers HOME WORK	
Mother's CELL/MOBILE PHONE		Father's CELL / MOBILE PHONE	
OPTIONAL: Mother's e-mail (will not be used to provide results, only as a way to contact you)		OPTIONAL: Father's e-mail (will not be used to provide results, only as a way to contact you)	
MOTHER'S EMPLOYER		FATHER'S EMPLOYER	

PATIENT'S GUARDIAN

NAME	Social Security No.	RELATIONSHIP TO PATIENT
ADDRESS	EMPLOYER	
CITY STATE ZIP	PHONE NO. HOME WORK	
If FOSTER CARE, list Dept. of FCS County and SOCIAL WORKER		

Patient Name: _____

PEDIATRICIAN / PRIMARY CARE PHYSICIAN

LAST	FIRST	PHONE NUMBER	FAX NUMBER
STREET	CITY STATE ZIP		E-MAIL

REFERRING PHYSICIAN (If different from Primary Care Physician)

LAST	FIRST	PHONE NUMBER	FAX NUMBER
STREET	CITY STATE ZIP		E-MAIL

Who can we speak to regarding your child (Grandmother, aunt, etc.)

LAST	FIRST	PHONE NUMBER	Relationship to Patient
LAST	FIRST	PHONE NUMBER	Relationship to Patient

FINANCIAL INFORMATION

Please bring all INSURANCE CARDS and REFERRAL FORMS to every visit

PRIMARY INSURANCE	EFFECTIVE DATE	**SECONDARY INSURANCE**	EFFECTIVE DATE
INSURANCE COMPANY NAME		INSURANCE COMPANY NAME	
ADDRESS TO MAIL CLAIM		ADDRESS TO MAIL CLAIM	
CITY STATE ZIP		CITY STATE ZIP	
TELEPHONE NUMBER		TELEPHONE NUMBER	
NAME OF POLICY HOLDER		NAME OF POLICY HOLDER	
POLICY HOLDER'S SOCIAL SECURITY No.		POLICY HOLDER'S SOCIAL SECURITY No.	
GROUP NO.	POLICY NO.	GROUP NO.	POLICY NO.

I. FINANCIAL AGREEMENT.

I hereby assume full responsibility for all charges incurred for professional services rendered by APNNA – Arizona Pediatric Neurology & Neurogenetics Associates, PLLC providers, unless the services are deemed "paid in full" as a result of a contractual agreement between APNNA - Arizona Pediatric Neurology & Neurogenetics Associate,s PLLC and my insurer. I understand that all charges not covered by my insurer, including copays, co-

Patient Name: _____

insurance, deductibles, and any charges for which I have failed to secure a referral or prior authorization are due at the time of service. If I am not prepared to pay my copay or deductible at the time of service, my appointment may be rescheduled if medically appropriate. I understand that my insurance is billed as a courtesy and I am responsible for payment of balance in full if not paid within 30 days. I understand that if APNNA – Arizona Pediatric Neurology & Neurogenetics Associates, PLLC does not participate with my insurance plan, I will be responsible for payment in full at the time services are rendered.

II. GROUP AND INDIVIDUAL INSURANCE, ASSIGNMENT OF BENEFITS

I authorize my health insurance benefit plan to pay directly to APNNA – Arizona Pediatric Neurology & Neurogenetics Associates, PLLC the surgical and/or medical benefits, if any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand that I am financially responsible to APNNA – Arizona Pediatric Neurology & Neurogenetics Associates, PLLC for charges not covered by this assignment.

Signature of Responsible Party: _____

Printed Name: _____ Date: _____