Banner
Children's Specialists

❑ New Patient ❑ Follow Up ❑ Post Op

Patient Information:

Name (Last, First, Middle):			DOB:	Sex:	Spoken Language:
Street Address:			City, State, Zip		Home Phone:
Primary Care Physician: Phone:			Referred By: Phone:		

❑ Parent ❑ Guardian Information ❑ Foster parent

Name (Last, First, Middle): #1			Name (Last, First, Middle): #2		
SSN#:	DOB:	Relationship to Patient:	SSN#:	DOB:	Relationship to Patient:
Street Address:			Street Address:		
City, State, Zip		Home Phone:	City, State, Zip		Home Phone:
Work Phone: Ext:		Cell Phone:	Work Phone: Ext:		Cell Phone:
Email:			Email:		

Case manager name: Phone: Fax:

Primary Insurance:

Name of Insurance Company:			Name of Insured (Last, First, Middle):		
Policy #:	Group #:		Employer:		
Claims Mailing Address:			Employer Address:		
City, State, Zip:		Phone #:	Copay Amt $	Deductible Amt $	Phone #:

Secondary Insurance:

Name of Insurance Company:			Name of Insured (Last, First, Middle):		
Policy #:	Group #:		Employer:		
Claims Mailing Address:			Employer Address:		
City, State, Zip:		Phone #:	Copay Amt $	Deductible Amt $	Phone #:

Emergency Contact:

Name (Last, First, Middle):		Relationship to Patient:	
Home Phone:	Cell Phone:	Work Phone:	Alternate Phone:

Check one or more: ❑ Asian ❑ Black/African American ❑ American Hispanic ❑ Refused
❑ Native American/Alaskan Native ❑ Pacific Islander/Native Hawaiian ❑ White ❑ Multiracial

I assign all medical and/or surgical benefits to which I am entitled, under private insurance, or any other health plan to Banner Health. I authorize the release of my medical information necessary to process claims and direct payment of benefits from my insurance company. I accept financial responsibility for all charges, including but not limited to, copayments and annual deductibles. Be signing below, I hereby acknowledge that I have received a Notice of Privacy Policy and my Medical Treatment Agreement. *This includes my email and phone communication preferences, as well as, the Consent to Treat agreement.*

Existing Patient Only: Would you like to make changes to the Medical Treatment Agreement at this time? Check One: Yes ❑ No ❑

A separate release is required for release of copies of records. May we leave a message on your voicemail at home and cell? Yes ❑ No ❑

Signature of Parent/Guardian

Date