

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

**Patient Information:**

Patients legal name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Male/Female  
Current Address \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Social Security# \_\_\_\_\_  
Parents Employer: \_\_\_\_\_ Occupation \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_

**Whom may we contact in the event of an emergency?**

Name: \_\_\_\_\_ Relation \_\_\_\_\_  
Phone # \_\_\_\_\_

**Primary Insurance Information:**

**Secondary Insurance Information:**

Ins. that will be billed first:	Ins. That will be billed second
Ins. Company Name: _____	Ins. Company name: _____
Phone number: _____	Phone # _____
Mailing Address: _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
ID # _____	ID # _____
Group # _____	Group # _____
Policy Holder Name _____	Policy Holder Name _____
SS# _____ D.O.B. _____	SS# _____ D.O.B. _____
Relation: _____	Relation _____

**If you are unable to bring your child in please list below who is responsible for making medical decisions:**

Name \_\_\_\_\_ Relation \_\_\_\_\_  
Name \_\_\_\_\_ Relation \_\_\_\_\_  
Name \_\_\_\_\_ Relation \_\_\_\_\_

**How did you hear about Chandler Pediatrics:**

\_\_\_\_\_  
\_\_\_\_\_

**Consent to treat:**

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 acknowledge that I have received the Chandler Pediatrics Notice Of Privacy Policy: (located at the front desk)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_