Patient Information Form-2026

Name: _____ **DOB:** _____/_____/_____ **Sex: M or F**

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Address: _____ **City:** _____ **State:** ____ **Zip:** _____

1st Phone: _____ **2nd Phone:** _____ **E-mail:** _____

Mother Step-Mother Legal Guardian *(Please circle one)*

Name: _____

Marital Status: _____ DOB : ____/____/____

SS#: _____

Phone # : _____

Occupation: _____

Father Step-Father Legal Guardian *(Please circle one)*

Name: _____

Marital Status: _____ DOB:___/___/_____

SS#: _____

Phone #: _____

Occupation: _____

Guarantor (person who holds the insurance and is responsible for your account)

Guarantor Name: _____ DOB: ____/_____/_____

Address (if different than above): _____ City:_____ State:___ Zip: _____

Relationship to Patient (s): _____Employer:_____

E-mail: _____ Phone #: _____

Insurance Information:

Primary Insurance: _____ Policy ID #: _____

_____ Please initial here if you do not have health insurance

How did you hear about Valley of the Sun Pediatrics: _____

Other siblings not being registered on this form:

Brothers: _____ Sisters: _____

Authorization to Pay Benefits to Valley of the Sun Pediatrics:

I hereby authorize Valley of the Sun Pediatrics to release any medical information needed to process insurance claims and authorize payments directly to Valley of the Sun Pediatrics for all medical and surgical benefits. I agree that I am financially responsible on the day of service for any charges not covered by this authorization or not covered by my insurance policy(s).

Parent or Guardian Signature: _____ **Date:** _____

Consent Form

Patient Name: _____ **DOB:** _____/_____/_____ **Sex: M or F**

Patient Name: _____ **DOB:** _____/_____/_____ **Sex: M or F**

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Patient Name: _____ **DOB:** ____/_____/_____ **Sex: M or F**

I authorize the following people to represent me at Valley of the Sun Pediatrics if I am unable to personally authorize medical services for the above patients. All names below are age 18 or older. This authorization is valid until withdrawn in writing:

_____

Name (other than person completing this form or other parent/guardian) Relationship to patient Phone

_____

Name (other than person completing this form or other parent/guardian) Relationship to patient Phone

Other authorization instructions if any:

_____

Authorization for Test Results (By checking the box you are authorizing us to leave a message)

Abnormal	Normal	
☐	☐	1st Phone _____
☐	☐	2nd Phone _____
☐	☐	Work Phone_____
☐	☐	Other Contact (name, relationship, phone number)_____

Pharmacy Information

Name: _____ Address: _____

EMERGENCY CONTACT INFORMATION (Other than a parent and at a different address)

Emergency Contact:_____

Relationship to Patient: _____ 1st Phone: _____ 2nd Phone: _____

Printed Name of Parent or Guardian:_____

Signature of Parent or Guardian: _____

Relationship to Patients:_____ Date:_____

Secondary Insurance

Complete either section A or B

A) My Family DOES NOT have a secondary insurance policy.

Parent or Guardian Name: _____ Date: _____

Parent or Guardian Signature: _____

B) My Family DOES have a secondary insurance policy.

Patients covered by secondary policy:

Name: _____ DOB: _____/_____/_____ Sex: M or F

Name: _____ DOB: _____/_____/_____ Sex: M or F

Name: _____ DOB: ____/_____/_____ Sex: M or F

Name: _____ DOB: ____/_____/_____ Sex: M or F

Insurance Information:

Secondary Insurance: _____ Policy ID #: _____

Policy Holder Name_____ DOB: _____/_____/_____

Note: We will bill your secondary insurance one time. If payment is not received within 30 days the visit balance will be applied to your account.

Parent or Guardian Name: _____ Date: _____

Parent or Guardian Signature: _____

Past Medical History

Patient Name _____ Age: _____ Sex: M or F

Allergies:_____

Current Medicines:_____

Medical History

BIRTH HISTORY (Please list birth weight, any pregnancy complications or birth complications)

_____

_____ONGOING

ILLNESSES (Please list any ongoing medical illnesses. i.e. Asthma, Eczema, Heart Murmurs, etc.)

_____

_____

Hospitalizations / Surgeries

(Please list any hospitalization and/or surgeries, include dates and reasons)

_____

_____

_____

Family History

(Please list any history of medical conditions or genetic disorders for immediate family members: parents and siblings)

_____

_____

_____

Social History

Are birth parents married to each other? Y N

Smokers at home? Y N

Is patient in daycare? Y N

Pets at home? Y N

Family Religion?_____

Types of pets?_____

Responsible Party Name (Print): _____

Responsible Party Signature: _____ Date: _____

Medical Records Release (One patient per form please)

Patient Name

:_____ DOB:_____

Address:_____

Home Phone: _____Cell Phone: _____Work Phone:_____

I hereby voluntarily authorize the disclosure/release of all medical records:

Circle One: **To** or **From**

Valley of the Sun Pediatrics, P.C

6635 W. Happy Valley Rd. Ste A104-503
Glendale, AZ 85310
623-362-1818 (phone)
623-362-8095 (fax)

Check purpose of release:

___ Transfer to new physician (Complete records including Immunization records)
___ Immunizations records only
___ Other (describe) _____

_____

Circle One: **To** or **From**

Physician, Facility or Hospital: _____

Facility Address: _____

Phone: _____

Fax: _____

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. This authorization may be revoked in writing at any time. The disclosed information may be subject to redisclosure by the recipient. This authorization expires six months from the date signed.

Parent or Guardian Name (print):_____Relationship to Patient:_____

Parent or Guardian Signature:_____ Date:_____

NOTE: PLEASE PROVIDE THIS DOCUMENT TO THE FACILITY OR PHYSICIAN THAT CURRENTLY HAS YOUR RECORDS

Office Policy Summary (2026)

Please Initial All

_____ **Account Balances**: **Due at check in for all family members accounts**.

_____ **Waiting Rooms:** Upon arrival, please enter the "Well Waiting Room" or the "Sick Waiting Room". We ask that you use the "Sick Waiting Room" if the patient or parent has any symptoms that may be contagious, for example, cough, nausea, etc. Note that limited cell phone use in the waiting room area is allowed, but use of any electronic devices in exam rooms are prohibited. Masks are optional in our offices.

_____ **Well Visits/Sick Visits:** Most insurance companies do not allow well and sick/office visits on the same day; To avoid being unexpectedly billed for an unallowable charge, our policy is have either a well or sick/office visit, but not both, on any given day; If you have a scheduled well visit and your child is ill or has a condition that would require a sick/office visit, please notify us at check-in and we will change your appointment to a sick/office visit. If, after conducting a well visit, we are requested to treat any medical situation you may be responsible for additional services beyond the well visit. I understand that I am responsible for the cash pay price of any vaccinations/injections requested and drawn up but then not administered due to refusal of patient and/or parent. Also note that the provider may send patient specimens to independent outside labs for analysis and that you may be billed for these services by the lab.

_____ **Billing Codes**: We are legally obligated to assign billing codes at the time of the service based on the services provided.

_____ **Inappropriate language**: **Will not be tolerated in our office or on phone calls with our staff. Such behavior will result in termination of provider/patient relationship.**

_____ **Insurance Policies**: **You are responsible to understand your insurance policy.** For deductible and co-insurance plans, if not charged at time of visit you will be billed monthly after processing by your insurance company. You are responsible for any services not covered by your plan. Please call our billing office if you have any questions. **You are responsible for updating us with new address, phone number and insurance information.**

_____ **After Hours Fee**: Applies to weekday appointments after 4:30PM and anytime on Saturday; Patient responsibility if not paid by your insurance company; Cash pay amount is $50.00.

_____ **No Show Policy**: Cancellations require 24 hours advance notice; **A $50.00 fee will be applied to your account if you no show or late cancel.** Note that if you are more than 15 minutes late for an appointment you may be required to reschedule and a no-show fee will be applied to your account.

_____**Forms:** We have established a fee of $50.00 for all Family and Medical Leave Act (FMLA), Handicap or Adoption forms and $25.00 for daycare, school and sports physical forms not brought in during a routine physical examination and other forms requiring the providers review and signature. Please allow five business days for these forms to be completed.

_____ **Payment Options**: We accept Visa, Master Card or cash at the time of your visit. Account balances may also be paid on-line or by check.

_____ **Late Payment/Collection Fees**: Statements are mailed monthly for all balances over $10.00; Payment is due upon receipt; A $20 fee will be applied to accounts that require a second billing cycle; A 40% collections fee will be applied to accounts that are sent to collections.

I understand and agree to the above policies and I have read and agree with the Office and Financial Policy and Notice of Privacy Policy of Valley of the Sun Pediatrics.

Parent or Guardian Name (Print): _____

Parent or Guardian Signature: _____Date: _____

Patient Eligibility Screening Record
Vaccines for Children Program

Date: _____ **Primary Provider's Name**: Ashley L. Hineman, MD
MM/DD/YYYY

This Form will help our office determine your eligibility for the Vaccines for Children program. If you meet the requirements, we can provider immunizations for your child at a reduced fee.

Child's Name: _____ **Date of Birth**: _____
Last Name First Name MI MM/DD/YYYY

Parent/Guardian: _____
Last Name First Name MI

Does this patient qualify for immunizations through the VFC program because he/she:

- ☐ a) **Yes**, is enrolled in Medicaid
- ☐ b) **Yes**, does NOT have health insurance
- ☐ c) **Yes**, is an American Indian or Alaska Native
- ☐ d) **NO**, is underinsured (has health insurance that does not cover immunizations)
- ☐ e) **NO**, has insurance that covers immunizations

Screening Updates:

(This is to be updated/recorded below at each visit where VFC vaccines are given to a child)

	VFC Eligibile Please check only ONE category			**NOT ELIGIBLE**	
Date of Screening	Is enrolled in Medicaid	Does NOT have health insurance	Is an American Indian or Alaska Native	Is underinsured (has health insurance that does not cover immunizations)	Has health insurance that covers immunizations

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not change. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.