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:** _____