

AHWATUKEE PEDIATRICS, P.C.

Mary Jo F. Kutler, D.O., F.A.C.O.P.

Dianne Olson, R.N., P.N.P.

NEW PATIENT INFORMATION RECORD

Date: _____

Patient's Name: _____ Date of Birth: _____ Sex: ___ Race: _____
(First, Mid. Init., Last)

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Maiden Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact (other than spouse): _____ Phone No.: _____

Mother's Social Security No.: _____ Home Phone No.: _____

Mother's Cell Phone No.: _____ Mother's Work Phone No.: _____

Father's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Father's Social Security No.: _____ Home Phone No.: _____

Father's Cell Phone No.: _____ Father's Work No.: _____

Person Responsible for Payment: _____ Policy Holder: _____

Policy Holder Employer: _____ Address: _____

Primary Insurance Name: _____

Insurance Claims Address: _____

Policy No.: _____ Group No.: _____

Secondary Insurance Name: _____

Insurance Claims Address: _____

Policy No.: _____ Group No.: _____

***If copay is not paid at time of service, a \$10.00 service charge will be charged to your account.**

AUTHORIZATION: I hereby authorize the physician indicated above to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Responsible Party Signature: _____