



DESERT RIDGE CHILDREN'S CENTER

20950 N Tatum Blvd # 200
Phoenix AZ 85050
Telephone: (480) 585 5200
Fax: (480) 585 5233



www.desertridgekids.com

Patient Information

Child's last name _____ First Name _____
Referred by: _____ Sex: M / F Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____

Parent/ Legal Guardian Information

Last name _____ First Name _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ SSN: _____
Employer: _____ Employer Phone Number: _____

Emergency Contact

Last name _____ First Name _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____

Guarantor Information:

Last name _____ First Name _____ DOB: _____
Relationship to the patient: _____ SSN: _____
Employer: _____ Name of Insurance: _____
Insurance ID #: _____ Group #: _____

Insurance Assignment and Release

I certify that I have insurance with _____ and assign directly to Dr. Rajeev Agarwal all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurances benefits or the benefits payable for related services. This consent will remain in effect till specifically requested as such by me.

Medicare Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Dr. Rajeev Agarwal dba Desert Ridge Children's Center.

To the extent permitted by law, I authorize any holder of medical or other information about my child to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Parent, Guardian of Personal Representative: _____

Date: _____ Relationship to Patient: _____