SPRINGFIELD PEDIATRICS

The best professionals linked to the patient experience for better outcomes

270 E Hunt Highway, Ste 18
San Tan Valley, AZ 85143

Diji Vaughan M.D., F.A.A.P.
Pediatrics Board Certified

Tel: (480)-336-2815
Fax: (877)-281-3385
www.springfieldpeds.com
contactus@springfieldpeds.com

Patient Registration Information

PATIENT INFORMATION – Please **enter for all children to be seen at the practice**

CHILD'S NAME (LAST, FIRST, MIDDLE)	PREFERED NAME	DATE OF BIRTH	SEX	RACE / ETHNICITY
CHILD'S NAME (LAST, FIRST, MIDDLE)				
CHILD'S NAME (LAST, FIRST, MIDDLE)				
CHILD'S NAME (LAST, FIRST, MIDDLE)				

PATIENT ADDRESS – Patient(s) reside(s) with: ☐ both parents ☐ mother ☐ father ☐ other _____

ADDRESS (STREET AND APT OR PO BOX)	CITY	STATE	ZIP

PHARMACY INFORMATION – Where you want your prescription sent

PHARMACY NAME	ADDRESS OR MAJOR CROSS STREETS	PHONE

GUARANTOR INFORMATION – The person financially responsible for the patient, usually the one holding the insurance

NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY #

ADDRESS, IF DIFFERENT FROM THE PATIENT (STREET AND APT OR PO BOX)	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	EMAIL ADDRESS	EMPLOYER	WORK PHONE

OTHER PARENT INFORMATION

NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY #

ADDRESS, IF DIFFERENT FROM THE PATIENT (STREET AND APT OR PO BOX)	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	EMAIL ADDRESS	EMPLOYER	WORK PHONE

INSURANCE INFORMATION – Please present insurance card(s) to the receptionist

PRIMARY INSURANCE (Company that will be biilled first)			SECONDARY INSURANCE (Company that will be billed second, if one)		
GROUP NUMBER	POLICY NUMBER	CO-PAYMENT	GROUP NUMBER	POLICY NUMBER	CO-PAYMENT

HOW DID YOU HEAR ABOUT US?

ARE THERE ANY RELIGIOUS PREFERENCES OR ACCOMODATIONS?

EMERGENCY CONTACT – When parents are not available

NAME (LAST, FIRST)	RELATIONSHIP	HOME PHONE	CELL PHONE

Assignment of Benefits: In the event the patient, his/her authorized representative or the guarantor signing below, is entitled to benefits of any type arising out of any policy of insurance insuring the patient or any other party liable for the patient, those benefits are hereby assigned to Springfield Medical LLC dba Springfield Pediatrics to the patient's bill. Such payment shall discharge the insurance company of any obligation under the policy to the extent that the payment has been made accordingly to the terms of the policy. The undersigned shall remain responsible for any and all charges not paid by the insurance company and/or covered by this assignment. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable for this patient, is hereby assigned to Springfield Pediatrics.

Parent/Guardian Signature: _____ Date: _____

Financial Responsibility: I agree that in return for the services provided to the patient by Springfield Pediatrics and/or any assisting physicians or providers, I will pay the account of the patient prior to discharge or make financial arrangements satisfactory to Springfield Pediatrics. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. A delinquent account (60 days from date of service) will be charged a $10.00 billing fee and may be charged interest at the legal rate.

Parent/Guardian Signature: _____ Date: _____

SPRINGFIELD PEDIATRICS

The best professionals linked to the patient experience for better outcomes

270 E Hunt Highway, Ste 18
San Tan Valley, AZ 85143

Diji Vaughan M.D., F.A.A.P.
Pediatrics Board Certified

Tel: (480)-336-2815
Fax: (877)-281-3385
www.springfieldpeds.com
contactus@springfieldpeds.com

Consent to Treat and / or Release: I hereby authorize SPRINGFIELD PEDIATRICS and its providers to examine and treat me and/or my minor child when necessary. I also authorize the release of my/our protected health information (PHI), acquired in the course of examination to carry out treatment, payment and healthcare operations (TPO) on our behalf. This consent shall remain in effect until revoked in writing.

Parent/Guardian Signature _____ Date: _____