

**RONALD A. GOODSITE, M.D.**

6620 EAST CARONDELET  
TUCSON, AZ 85710  
520-296-3248

Ronald A. Goodsite, M.D.

Brendyn Thé, FNP

**Patient Information**

<b>Patient's Name</b> _____	<b>Date of Birth</b> _____
Address _____	
City _____	State _____ Zip _____
Sex _____	Phone _____ Work _____
Full Time Student _____	School Name _____
Allergies _____	
Social Security # _____	City of Birth _____

**Responsible Party Information**

<b>1.) Mother's Name</b> _____	<b>Date of Birth</b> _____
Address _____	
City _____	State _____ Zip _____
Home # _____	Work # _____
Employer _____	
<b>2.) Father's Name</b> _____	<b>Date of Birth</b> _____
Address _____	
City _____	State _____ Zip _____
Home # _____	Work # _____
Employer _____	

**Insurance Information**

Primary Insurance _____	ID # _____
Address _____	City _____ State _____
Zip _____	Phone _____ / _____
Policy Holder Name _____	Relationship _____
Secondary Insurance _____	ID # _____
Address _____	City _____ State _____
Zip _____	Phone _____ / _____
Policy Holder Name _____	Relationship _____

**Emergency Contact**

Name _____	Relation _____	Phone# _____
Address _____	City _____	State _____ Zip _____

**Release and Assignment of Benefits:** I/We hereby authorize Ronald A Goodsite, M.D. to release records pertaining to my child's treatment to my insurance company or other third parties responsible for payment of medical charges, including review activities related to Ronald A. Goodsite, M.D.'s participation with my/our health plan. 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 they are covered by my Insurance.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date