PATIENT INFORMATION

PATIENT AND INSURED
(SUBSCRIBER) INFORMATION

PLEASE RETURN THIS FORM TO THE RECEPTIONIST WHEN COMPLETE

PATIENT'S FULL NAME (CHILD'S #1) | SEX ☐ MALE ☐ FEMALE | DATE OF BIRTH | AGE

PATIENT LIVES WITH - FULL NAME | ADDRESS | CITY | STATE | ZIP CODE | HOME PHONE

Please check- Race: ☐ Declined ☐ American Indian/Alaska Native ☐ Asian ☐ Blk/African American ☐ Nat Hawaiian/Pacific Islander ☐ Other ☐ Unknown ☐ Wht/Caucasian

Please check- Ethnicity: ☐ Declined ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown Primary Language_____

FATHER / GUARDIAN (circle one)				MOTHER / GUARDIAN (circle one)			
FULL NAME	DATE OF BIRTH			FULL NAME	DATE OF BIRTH		
STREET ADDRESS	CITY	STATE	ZIP CODE	STREET ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE			HOME PHONE	CELL PHONE		
EMPLOYER	WORK PHONE W/EXT.			EMPLOYER	WORK PHONE W/EXT.		

PLEASE INDICATE WHICH OF THE ABOVE PHONE NUMBERS IS THE PREFERRED CONTACT NUMBER FOR YOUR CHILD/CHILDREN ACCOUNT: ☐ FATHER'S HOME, ☐ FATHER'S CELL, ☐ FATHER'S WORK ☐ MOTHER'S HOME, ☐ MOTHER'S CELL, ☐ MOTHER'S WORK

PRIMARY INSURANCE INFORMATION		SECONDARY INSURANCE INFORMATION	
NAME OF PRIMARY INSURANCE CO.		NAME OF SECONDARY INSURANCE CO.	
NAME OF INSURED /SUBSCRIBER(AS IT APPEARS ON THE INSURANCE CARD)	INSURED'S / SUBSCRIBER DATE OF BIRTH	NAME OF INSURED /SUBSCRIBER(AS IT APPEARS ON THE INSURANCE CARD)	INSURED'S / SUBSCRIBER DATE OF BIRTH
CONTRACT NUMBER	GROUP NUMBER	CONTRACT NUMBER	GROUP NUMBER
EFFECTIVE DATE	RELATIONSHIP TO CHILD	EFFECTIVE DATE	RELATIONSHIP TO CHILD

PATIENT'S FULL NAME (CHILD'S #2) | SEX ☐ MALE ☐ FEMALE | DATE OF BIRTH | AGE

Please check- Race: ☐ Declined ☐ American Indian/Alaska Native ☐ Asian ☐ Blk/African American ☐ Nat Hawaiian/Pacific Islander ☐ Other ☐ Unknown ☐ Wht/Caucasian

Please check- Ethnicity: ☐ Declined ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown Primary Language_____

PRIMARY INSURANCE INFORMATION		SECONDARY INSURANCE INFORMATION	
NAME OF PRIMARY INSURANCE CO.		NAME OF SECONDARY INSURANCE CO.	
NAME OF INSURED /SUBSCRIBER(AS IT APPEARS ON THE INSURANCE CARD)	INSURED'S / SUBSCRIBER DATE OF BIRTH	NAME OF INSURED /SUBSCRIBER(AS IT APPEARS ON THE INSURANCE CARD)	INSURED'S / SUBSCRIBER DATE OF BIRTH
CONTRACT NUMBER	GROUP NUMBER	CONTRACT NUMBER	GROUP NUMBER
EFFECTIVE DATE	RELATIONSHIP TO CHILD	EFFECTIVE DATE	RELATIONSHIP TO CHILD

PATIENT'S FULL NAME (CHILD'S #3) | SEX ☐ MALE ☐ FEMALE | DATE OF BIRTH | AGE

Please check- Race: ☐ Declined ☐ American Indian/Alaska Native ☐ Asian ☐ Blk/African American ☐ Nat Hawaiian/Pacific Islander ☐ Other ☐ Unknown ☐ Wht/Caucasian

Please check- Ethnicity: ☐ Declined ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown Primary Language_____

PRIMARY INSURANCE INFORMATION		SECONDARY INSURANCE INFORMATION	
NAME OF PRIMARY INSURANCE CO.		NAME OF SECONDARY INSURANCE CO.	
NAME OF INSURED /SUBSCRIBER(AS IT APPEARS ON THE INSURANCE CARD)	INSURED'S / SUBSCRIBER DATE OF BIRTH	NAME OF INSURED /SUBSCRIBER(AS IT APPEARS ON THE INSURANCE CARD)	INSURED'S / SUBSCRIBER DATE OF BIRTH
CONTRACT NUMBER	GROUP NUMBER	CONTRACT NUMBER	GROUP NUMBER
EFFECTIVE DATE	RELATIONSHIP TO CHILD	EFFECTIVE DATE	RELATIONSHIP TO CHILD

IN CASE OF AN EMERGENCY NOTIFY (OTHER THAN LISTED ABOVE)

FULL NAME	PHONE	RELATIONSHIP TO CHILD
FULL NAME	PHONE	RELATIONSHIP TO CHILD

I AUTHORIZE THE STAFF AND PHYSICIANS OF SUNSHINE PEDIATRICS TO DISCUSS ANY MEDICAL OR FINANCIAL INFORMATION WITH THE FOLLOWING INDIVIDUALS:

FULL NAME	FULL NAME

PATIENT PORTAL: ☐ No, I DO NOT wish to register to access my child's patient portal

☐**YES**, I would like to register to access my above child's/children's patient portal. My email address is: _____

CELLULAR TELEPHONE NUMBER: I, the parent or guardian of the above child/children, do hereby authorize Sunshine Pediatrics to send automated voice [___ Yes / No ___] and or text [___Yes / No ___] appointment reminder messages to the above cellular telephone number.

CONSENT FOR TREATMENT: I, the parent or guardian of the above child/children, do hereby authorize Sunshine Pediatrics and all of its physicians to give to the child/children any treatment or immunization that such physicians deem necessary for their health. ☐ YES ☐ NO

LIMITED RELEASE OF INFORMATION: I, authorize the release of all medical information on the child/children to any physicians or insurance carriers. ☐ YES ☐ NO

FINANCIAL RESPONSIBILITY: I, acknowledge that I am totally responsible for all charges for services rendered to the child/children. If this account is referred to an attorney for collection, I agree to pay all costs of collections, including a reasonable attorney fee. ☐ YES ☐ NO

CONSENT TO OBTAIN PAST PRESCRIPTION HISTORY: I, the parent or guardian of the above child/children, do hereby authorize Sunshine Pediatrics and its physician to obtain past prescription history for my child/children as deemed necessary. YES ☐ NO ☐

CONSENT TO ENROLL IN CHADIS: I, the parent or guardian of the above child/children, do hereby authorize Sunshine Pediatrics and its physician to enroll in CHADIS for developmental questionnaires in accordance with my child/children's care. YES ☐ NO ☐

Signature of responsible party _____ Date _____