Patient Registration Form

Children's Information (List all your children below). Ask for an additional sheet if needed.

Child #1: Last Name: _____ First Name: _____ SS# _____

Preferred Name: _____

DOB: _____/_____/_____ Sex: M/F Preferred Language: _____

Ethnicity: Hispanic or Latino/ Non-Hispanic or Latino/ Unknown or Decline

Race: African American / American Indian or Native Alaskan / Asian / Hawaiian or Pacific Islander / Caucasian / Other or Decline

Child #2: Last Name: _____ First Name: _____ SS# _____

Preferred Name: _____

DOB: _____/_____/_____ Sex: M/F Preferred Language: _____

Ethnicity: Hispanic or Latino/ Non-Hispanic or Latino/ Unknown or Decline

Race: African American / American Indian or Native Alaskan / Asian / Hawaiian or Pacific Islander / Caucasian / Other or Decline

Child #3: Last Name: _____ First Name: _____ SS# _____

Preferred Name: _____

DOB: _____/_____/_____ Sex: M/F Preferred Language: _____

Ethnicity: Hispanic or Latino/ Non-Hispanic or Latino/ Unknown or Decline

Race: African American / American Indian or Native Alaskan / Asian / Hawaiian or Pacific Islander / Caucasian / Other or Decline

Child #4: Last Name: _____ First Name: _____ SS# _____

Preferred Name: _____

DOB: _____/_____/_____ Sex: M/F Preferred Language: _____

Ethnicity: Hispanic or Latino/ Non-Hispanic or Latino/ Unknown or Decline

Race: African American / American Indian or Native Alaskan / Asian / Hawaiian or Pacific Islander / Caucasian / Other or Decline

How did you hear about us? _____

Insurance (Skip if we have a copy of your card.)

Primary Policy Holder Name: _____

Policy Holder's DOB (M/D/YYYY) _____/_____/_____

Relationship to Patient: _____

Insurance Carrier: _____

ID #: _____ Group #: _____

Parent Information:

Parent #1/Guardian/Other (Parent to contact first)

Name: _____

Relationship to Patient: _____

DOB: _____/_____/_____

Gender: Male/Female/Other

Cell #: _____

Home #: _____

Work #: _____

Email: _____

Address: _____

_____

Parent #2/Guardian/Other

Name: _____

Relationship to Patient: _____

DOB: _____/_____/_____

Gender: Male/Female/Other

Cell #: _____

Home #: _____

Work #: _____

Email: _____

Address: _____

_____

Who does your child(ren) live with? Circle one: Both / #1 / #2 / Guardian/Other

Party responsible for payment. Circle one: Both / #1 / #2 / Guardian/Other

If parents are divorced, separated, or not married, please fill out this section:

Who has primary custody? Circle one: #1 / #2 / Guardian/Other

Who has permission to access patient's records? Circle all that apply: Both / #1 / #2 / Guardian/Other

For any restrictions to records access, legal documentation is required.

Is legal documentation required? Y N Has legal documentation been provided? Y N

Date provided: _____/_____/_____

Emergency contact(s)/ List of people authorized to discuss aspects of patient care:

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

REQUEST FOR TRANSFER OF HEALTH INFORMATION/MEDICAL RECORDS

I hereby request a transfer of medical records in its entirety as allowed by law for:

Full name of patient: _____

Date of birth: _____/_____/_____

Full name of patient: _____

Date of birth: _____/_____/_____

Full name of patient: _____

Date of birth: _____/_____/_____

Address: _____

City/State/Zip Code: _____

Daytime Phone Number: (_____) _____ - _____ ☐ Cell ☐ Work ☐ Home

To be transferred from:

Practice Name: _____

Address: _____

City/State/Zip Code: _____

Phone Number: (_____) _____ - _____ Fax Number: (_____) _____ - _____

To be transferred to:

Sunshine Pediatrics

197 E University Dr, Ste 2

Auburn, AL 36832

P: (334) 329-7862 F: (334) 329-7879

Requestor's Signature: _____

Date: _____/_____/_____

Requestor's Printed Name: _____

Patient's Signature if over the age of 14: _____

Date: _____/_____/_____

By my signature I certify that I am the parent, legal guardian, or patient named here.

Official Term and Agreements

Please read and initial the following terms below.

Child(s) Name and DOB:

_____

(if multiple children you can list them all above)

_____ Consent to Treat: This gives Sunshine Pediatric physicians and staff permission to treat your child/children in case of a health emergency in our office and that would require immediate attention. Prior to any treatment or vaccinations the physician will discuss the risks and benefits of treatment and get verbal consent from the Parent/ Guardian. All vaccines are optional at our office.

☐ Yes, I would like to opt in for vaccines. ☐ No, I would not like to opt in for vaccines.

_____ Patient Portal: Patient portal gives you online access to your child's chart, where you can review records, send messages to the staff, appointment reminders and make online appointments. If you would like access please provide an email address below.

Email address: _____

_____ Cellular Telephone Number: The cell number provided to Sunshine Pediatrics is our main way of communication and we will use this number to send appointment reminders and contact you if needed. Please keep your phone number up to date.

_____ Financial Responsibility: Sunshine Pediatrics accepts assignment of insurance benefits from most major insurance companies for payment of services on your behalf. It remains your responsibility to verify coverage with your specific insurance policy before appointment. Any remaining amount not covered by your insurance is the patient's responsibility to pay.

_____ Limited Release of Information: This gives Sunshine Pediatrics permission to release your child/children's medical records to any physician and/or insurance carriers, for the purpose of insurance payments, referrals or any other specialty to help us maintain care of your child.

_____ CHADIS: Online developmental questionnaires that help assist the physicians in developmental diagnosis, anxiety, depression, ADHD, autism, etc.

_____ Obtaining Past Prescription History: Sunshine Pediatrics will obtain your child/children's past prescription history if we feel it will be in our patient's best interest to help continue their care.

_____

Signature

_____

Date