Sunshine Pediatrics Registration Forms

(**bold** indicates required information)

Today's Date _____

****Please note: a driver's license from BOTH parents will be required at the first visit****

Child's First _____ **Middle** _____ **Last** _____

Sex ☐ Male ☐ Female **Date of Birth** _____/_____/_____ Nickname _____

Address of Child's Primary Residence:

_____**City** _____ St_____ **Zip**_____

TELEPHONE NUMBERS

- Primary phone (#1) is the one to be used first for messages and reminder calls. This does not have to be the home phone.
- Please list phone numbers in the order to be called.

1. ( )	☐ Home ☐ Cell ☐ Work ☐Other/Ext: _____	☐ Mother ☐ Other: Name: _____ ☐ Father Rel: _____
2. ( )	☐ Home ☐ Cell ☐ Work ☐Other/Ext: _____	☐ Mother ☐ Other: Name: _____ ☐ Father Rel: _____
3. ( )	☐ Home ☐ Cell ☐ Work ☐Other/Ext: _____	☐ Mother ☐ Other: Name: _____ ☐ Father Rel: _____
4. ( )	☐ Home ☐ Cell ☐ Work ☐Other/Ext: _____	☐ Mother ☐ Other: Name: _____ ☐ Father Rel: _____
5. ( )	☐ Home ☐ Cell ☐ Work ☐Other/Ext: _____	☐ Mother ☐ Other: Name: _____ ☐ Father Rel: _____

**By providing us with your wireless or land line phone number, you are giving us your prior express consent to call those numbers for business purposes.*

PARENT / GUARDIAN INFORMATION

Mother's Full Name: _____ **Date of Birth** _____/_____/_____

Social Security # _____ - _____ - _____ **Relationship:** ☐ Mother ☐ Foster ☐ Legal Guardian ☐ Step ☐ Other:

Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Remarried ☐ Widowed

Address: ☐ Same as Child_____**City** _____ St _____ **Zip** _____

Employer _____ **Phone:** ( ) _____ ext: _____

Occupation: _____ Email: _____@_____

Father's Full Name: _____ **Date of Birth** _____/_____/_____

Social Security # _____ - _____ - _____ **Relationship:** ☐ Father ☐ Foster ☐ Legal Guardian ☐ Step ☐ Other:

Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Remarried ☐ Widowed

Address: ☐ Same as Child_____**City** _____ St _____ **Zip** _____

Employer _____ **Phone:** ( ) _____ ext: _____

Occupation: _____ Email: _____@_____

Step parents' name(s), if applicable: _____

Custodial parent, if applicable: _____

SIBLING INFORMATION

Child's Brothers' & Sisters' First Names	Last Names	Dates of Birth	Sex
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female

EMERGENCY / ALTERNATE CONTACT

Full Name _____Address/City/Zip_____

Relationship_____Ph# ( ) _____ or ( )_____

FINANCIAL RESPONSIBILITY

Invoices/Statements should be mailed to ☐ **Mother** ☐ **Father** ☐ **Other:** _____ (must be listed above)

(Both parents or legal guardians are legally responsible for any charges regardless of where the statements are mailed)

Insurance Information

Child's Name: First _____ Last_____**Date of Birth** _____

Primary Insurance

Cardholder's Full Name: First _____ Last _____

Social Security _____ Date of Birth _____ Relationship to child _____

Address (if different than child's) _____

City _____ State _____ Zip _____

Phone ( ) _____ Work ( ) _____

Employer _____ Business Phone ( ) _____

Employer Address_____City/State_____Zip_____

Insurance Company _____ID # _____ Group# _____

Effective Date of insurance _____

*****WE NO LONGER ACCEPT SECONDARY INSURANCE, EXCEPT IN CASES OF DISABILITY*****

Secondary Insurance

Cardholder's Full Name: First _____ Last _____

Social Security _____ Date of Birth _____ Relationship to child _____

Address (if different than child's) _____

City _____ State _____ Zip _____

Phone ( ) _____ Work ( ) _____

Employer _____ Business Phone ( ) _____

Employer Address_____City/State_____Zip_____

Insurance Company _____ID # _____ Group# _____

Effective Date of insurance _____

PAYMENTS AND INSURANCE AUTHORIZATION / ASSIGNMENT OF BENEFITS

It is the policy of this office that all payments for medical services be made *at the time of your visit, or before in some cases*. This payment is required regardless of who brings the child in to be seen. In the case of separated or divorced parents, responsibility and payment shall belong to the guardian bringing the child in for treatment. For example, if parent #1 is financially responsible for medical expenses, and parent #2 is bringing that child in for treatment, payment will still be expected from parent #2 at the time of service.

Initial_____ I understand and agree that regardless of what benefits are quoted, or misquoted, by my insurance company when you check my insurance status, I am ultimately responsible for any deductible, co-insurance/copays, or any other balance not paid by my insurance company. This includes services provided that the insurance company deems not medically necessary.

Initial_____ I understand that I must pay my copay or co-insurance at the time of service, regardless of who accompanies my child to his/her visit. Without my copay or co-insurance, I may be charged a late-fee.

Initial_____ I understand that I must pay my deductible responsibility, if I have one, at the time of service. If I cannot pay the entire deductible balance, a $50 deductible deposit will be required at each visit until my deductible has been met. If I request to be billed for a deductible balance, I must pay within 30 days, or I will lose the privilege of being billed. I will then be required to pay in full at each visit.

Initial_____ I must have proof of insurance at every visit or I will have to pay in full to be seen. If I have a newborn, I will have to present proof of application by the 30 day mark if I do not have my baby's proof of insurance by then.

Initial_____ I understand that I am responsible for any costs incurred in the collection of my child's account in case of default, including reasonable attorney fees, court fees and agency fees.

Initial_____ I understand that bad checks are sent to the York County Solicitor's Worthless Check Unit, for which there will be a $30 charge from our office. Failure to pay the check and all fees could result in arrest and criminal prosecution.

Initial_____ I understand that well and sick benefits may be handled differently by my insurance company, and if during a well visit, my child is sick, or has an issue needing treatment and/or medical attention, my provider may bill for both services. Regardless of what the well visit benefits are, I will be responsible for any charges my insurance passes on to me for the sick visit portion.

I hereby grant permission to Sunshine Pediatrics, LLC to release any pertinent information to my insurance company upon request, and I also authorize transfer of benefits to Sunshine Pediatrics, LLC. A photocopy of this authorization shall be considered as valid as the original.

Signature: _____Print Name _____ Date: _____

Sunshine Pediatrics

AUTHORIZATION FOR MEDICAL CARE

I (We) _____ and _____ authorize Sunshine
PRINT NAME OF MOTHER/ LEGAL GUARDIAN(S) PRINT NAME OF FATHER/ LEGAL GUARDIAN(S)
Pediatrics, LLC and its personnel to deliver medical services to my child(ren):

_____	_____	_____	_____
PRINT CHILD'S NAME	DATE OF BIRTH	PRINT CHILD'S NAME	DATE OF BIRTH
_____	_____	_____	_____
PRINT CHILD'S NAME	DATE OF BIRTH	PRINT CHILD'S NAME	DATE OF BIRTH
_____	_____	_____	_____
PRINT CHILD'S NAME	DATE OF BIRTH	PRINT CHILD'S NAME	DATE OF BIRTH

I (We) authorize the following people to **bring my child in for, and consent to, treatment, or receive medical advice over the phone if they are taking care of my child in my absence**. This does not allow them to have access to protected health information that is not pertinent to the visit. Please check the boxes to give them additional specific authorizations.*

Name: _____ Relationship: _____ ☐ May pick up prescriptions ☐ May pick up shot records

Name: _____ Relationship: _____ ☐ May pick up prescriptions ☐ May pick up shot records

Name: _____ Relationship: _____ ☐ May pick up prescriptions ☐ May pick up shot records

Name: _____ Relationship: _____ ☐ May pick up prescriptions ☐ May pick up shot records

*Any other type of documents to be picked up by someone other than the legal guardians listed above must have a separate written consent.

I (We) understand that telephone triage and advice services will ***not*** be extended to the above persons unless it is regarding direct patient care while the child is in their care. In the absence of written authorization for medical services, our office will try to reach you for verbal authorization. If, however, we cannot reach you, we will not refuse to treat your child. This serves as a consent for medical treatment that we deem as medically necessary and appropriate.

Patient/Parent/Legal Guardian Rights:

- I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Sunshine Pediatrics.
- I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____ _____ _____
Signature of Legal Guardian Date Relationship to patient

Printed name: _____

Sunshine Pediatrics

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of birth: _____

I have received a copy of the Notice of Privacy Practices from Sunshine Pediatrics.

Extra copies can be found:

- In the Welcome Packet located on the Forms/Policies page of our website: www.MySunshinePeds.com/policies.php
- At the front desk of our office

_____ _____ _____

Printed Name of Parent/Legal Guardian Signature Date

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgment of receipt of NPP because:

- ☐ An emergency existed and a signature was not possible at the time
- ☐ The individual refused to sign
- ☐ A copy was mailed with a request for a signature by return mail
- ☐ Unable to communicate with the parent/guardian for the following reason:

  _____

- ☐ Other

  _____

Prepared by: _____

Signature: _____ Date: _____

Pediatric History

Date: _____ Child's Last Name _____ First _____

Sex: ☐ M ☐ F Date of Birth _____Age_____ Primary Language: _____

Race_____☐ Decline to answer Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Decline to answer

Child's Dentist _____ Pharmacy & Ph#_____

Medication Allergies: Please list the substance and the reaction. If no known allergies, please write "no known allergies."

_____

Is your child up-to-date with his or her immunizations? ☐ Yes ☐ No Please bring us the most recent vaccine card or certificate.

Has your child ever had any reaction to any immunizations? If so, which vaccine and what was the reaction? If none, please write "none."

_____

Delivery and Birth History:

Delivery was: ☐ On time ☐ Premature ☐ Late ☐ Normal ☐ Induced ☐ Prolonged ☐ Breech ☐ C-Section
☐ Fetal distress ☐ Use of forceps or vacuum suction ☐ Other _____

Your newborn had: (Please describe in the space provided or write N/A)

☐ Birth Defects _____ ☐ Infection _____ ☐ Transfusion _____
☐ Breathing Problems _____ ☐ Jaundice _____ ☐ Other _____

Current and Past Medical History:

Please describe if your child has any of the following (write N/A if there is nothing to report). Please use additional sheets if needed.

Chronic (long-term) diseases/illnesses? _____

Developmental delays? If so, a) what kind of delay(s) and b) how is it being treated (i.e. by which kind of therapist or doctor):

_____

Previous hospitalizations? If so, please describe a) for what reason, b) when and c) for how long:

_____

Previous surgeries? If so, please describe a) for what reason and b) when:

_____

Previous fractures (broken bones)? If so, please describe a) which bone, b) how it happened, and c) when:

_____

Does your child see any specialists? If so, please give the a) name, b) the specialty, c) the reason you see him/her and d) their phone number:

_____

List all the prescription, over-the-counter, vitamins or herbal medication your child takes. Please include the a) dosage and b) how/when it is taken.

_____

Does your child smoke? ☐ Yes since the age of _____ ☐ No ☐ Unknown

Family History:

Please give the following information about your child's blood relatives:

Biological father's name _____ Current Age _____ If deceased: what age and how:_____

Biological mother's name _____ Current Age _____ If deceased: what age and how:_____

Biological Brothers/Sisters

Names: _____ Age _____ Medical problems _____
_____ Age _____ Medical problems _____
_____ Age _____ Medical problems _____

Have any children in your family died? _____ If yes, please explain how: _____

Are there smokers in your house? ☐ Yes How many people? _____ ☐ No/Do not suspect it ☐ Maybe/Unknown

Please check the conditions that any of the child's **blood relatives** have, and state their relationship to the child as well as on whose side they come from (mom vs. dad's). So as an example: If you write "grandma" add an 'M' to indicate that mom's mom has the condition. Please mark the N/A box if applicable.

Condition	Relationship to child		Condition	Relationship to child	
☐ Allergies	the child's_____	☐ N/A	☐ Genetic defects	the child's_____	☐ N/A
☐ Arthritis	the child's_____	☐ N/A	☐ Heart disease	the child's_____	☐ N/A
☐ Asthma	the child's_____	☐ N/A	☐ High Cholesterol	the child's_____	☐ N/A
☐ Blood Disorders	the child's_____	☐ N/A	☐ HIV/AIDS	the child's_____	☐ N/A
☐ Birth defects	the child's_____	☐ N/A	☐ Kidney disease	the child's_____	☐ N/A
☐ Bone/joint disorders	the child's_____	☐ N/A	☐ Lung disease	the child's_____	☐ N/A
☐ Cancer	the child's_____	☐ N/A	☐ Mental disease/disorder	the child's_____	☐ N/A
☐ Diabetes	the child's_____	☐ N/A	☐ Mental retardation	the child's_____	☐ N/A
☐ Eczema	the child's_____	☐ N/A	☐ Muscle disorders	the child's_____	☐ N/A
☐ Epilepsy/Seizures	the child's_____	☐ N/A	☐ Sickle cell anemia	the child's_____	☐ N/A
☐ Eye or ear disorders	the child's_____	☐ N/A	☐ Tuberculosis	the child's_____	☐ N/A

Please use an additional sheet to describe what else you would like us to know. Thank you.

Sunshine Pediatrics
724 Arden Lane, Suite 100
Rock Hill, SC 29732
803-980-PEDS (7337)
Fax: 803-980-BABY (2229)

REQUEST FOR RELEASE OF HEALTH RELATED INFORMATION

I hereby authorize and request that, for the child(ren) listed below, the following medical records be released (choose all that apply) from (choose where):

- ☐ All Records
- ☐ _____Results
- ☐ Include old records from previous primary care physician(s)
- ☐ SC Certificate of Immunization
- ☐ Physician Notes
- ☐ Complete Vaccine Record (non-certified)
- ☐ Payment History/Account Information
- ☐ Other: _____

From:
- ☐ Sunshine Pediatrics
- ☐ From another facility: Name: _____
  Location/Ph#: _____

for the following dates: from_____ to_____ for the purpose of: ☐ transfer ☐ personal copy ☐ release

The information is to be *released to* the following person or facility (choose):

- ☐ **Sunshine Pediatrics**, 724 Arden Lane, Suite 100, Rock Hill, SC 29732, Fax 803-980-2229
- ☐ Transfer or Release information to:
  Facility: _____ (addressee)
  Address: _____ City/St/Zip
  _____
  Phone: ( ) _____Fax: ( ) _____
  Attention to:_____Email_____
- ☐ Personal Copy to be released to: (Full name(s)) _____ (ID may be required)

The information is to be (choose): (Charges may apply)

- ☐ Mailed to the current home address
- ☐ Faxed to the above number
- ☐ Mailed to the above address
- ☐ Picked up in person
- ☐ Emailed (we cannot guarantee security)
- ☐ Discussed with above named party

Child(ren)'s Name(s):	**Date(s) of Birth:**	**Sex:**
		☐ M ☐ F
		☐ M ☐ F
		☐ M ☐ F
		☐ M ☐ F

I understand that there may be an associated charge for providing these records.

Parent/Legal Guardian Printed Name: Signature: Date:

_____ _____ _____**

**This authorization expires in 90 days from the above date.