



Sunshine Pediatrics Registration Forms

(bold indicates required information)



Today's Date _____

****Please note: a driver's license from at least one parent 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. ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other/Ext: _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Other: Name: _____ Rel: _____
2. ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other/Ext: _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Other: Name: _____ Rel: _____
3. ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other/Ext: _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Other: Name: _____ Rel: _____
4. ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other/Ext: _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Other: Name: _____ Rel: _____
5. ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other/Ext: _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Other: Name: _____ 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
			<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Male <input type="checkbox"/> 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

Policy holder'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 City/State _____ Zip _____
Insurance Company _____ ID # _____ Group# _____
Effective Date of insurance _____

WE DO NOT BILL SECONDARY COMMERCIAL INSURANCES

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 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 for payment shall belong to the guardian bringing the child in for treatment. For example, if parent #1 is financially responsible for medical expenses, but 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 coverage by the 60-day mark.

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 use and disclose my protected health information for treatment, payment, and healthcare operations. I also authorize transfer of benefits to Sunshine Pediatrics, LLC.

Signature: _____ Print Name _____ 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
<input type="checkbox"/> Allergies	the child's _____ <input type="checkbox"/> N/A	<input type="checkbox"/> Genetic defects	the child's _____ <input type="checkbox"/> N/A
<input type="checkbox"/> Arthritis	the child's _____ <input type="checkbox"/> N/A	<input type="checkbox"/> Heart disease	the child's _____ <input type="checkbox"/> N/A
<input type="checkbox"/> Asthma	the child's _____ <input type="checkbox"/> N/A	<input type="checkbox"/> High Cholesterol	the child's _____ <input type="checkbox"/> N/A
<input type="checkbox"/> Blood Disorders	the child's _____ <input type="checkbox"/> N/A	<input type="checkbox"/> HIV/AIDS	the child's _____ <input type="checkbox"/> N/A
<input type="checkbox"/> Birth defects	the child's _____ <input type="checkbox"/> N/A	<input type="checkbox"/> Kidney disease	the child's _____ <input type="checkbox"/> N/A
<input type="checkbox"/> Bone/joint disorders	the child's _____ <input type="checkbox"/> N/A	<input type="checkbox"/> Lung disease	the child's _____ <input type="checkbox"/> N/A
<input type="checkbox"/> Cancer	the child's _____ <input type="checkbox"/> N/A	<input type="checkbox"/> Mental disease/disorder	the child's _____ <input type="checkbox"/> N/A
<input type="checkbox"/> Diabetes	the child's _____ <input type="checkbox"/> N/A	<input type="checkbox"/> Mental retardation	the child's _____ <input type="checkbox"/> N/A
<input type="checkbox"/> Eczema	the child's _____ <input type="checkbox"/> N/A	<input type="checkbox"/> Muscle disorders	the child's _____ <input type="checkbox"/> N/A
<input type="checkbox"/> Epilepsy/Seizures	the child's _____ <input type="checkbox"/> N/A	<input type="checkbox"/> Sickle cell anemia	the child's _____ <input type="checkbox"/> N/A
<input type="checkbox"/> Eye or ear disorders	the child's _____ <input type="checkbox"/> N/A	<input type="checkbox"/> Tuberculosis	the child's _____ <input type="checkbox"/> N/A

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

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: _____

Sunshine Pediatrics

AUTHORIZATION FOR MEDICAL CARE

I (We) _____ and _____ authorize Sunshine Pediatrics, LLC and its personnel to deliver medical services to my child(ren):

PRINT NAME OF MOTHER/ LEGAL GUARDIAN(S) PRINT NAME OF FATHER/ LEGAL GUARDIAN(S)

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: _____	<input type="checkbox"/> May pick up prescriptions <input type="checkbox"/> May pick up shot records
Name: _____	Relationship: _____	<input type="checkbox"/> May pick up prescriptions <input type="checkbox"/> May pick up shot records
Name: _____	Relationship: _____	<input type="checkbox"/> May pick up prescriptions <input type="checkbox"/> May pick up shot records
Name: _____	Relationship: _____	<input type="checkbox"/> May pick up prescriptions <input type="checkbox"/> 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
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Printed name: _____



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

**REQUEST FOR TRANSFER OR
 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
- SC Certificate of Immunization
- Complete Vaccine Record (non-certified)
- _____ Results
- Physician Notes
- Payment History/Account Information
- Include old records from previous primary care physician(s)
- 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: _____ Attn: _____
 Address: _____ City/St/Zip _____
 Phone: () _____ Fax: () _____
- Personal Copy to be released to: (Full name(s)) _____ (ID may be required)
 Email _____

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

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

Child(ren)'s Name(s):	Date(s) of Birth:	Sex:
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> 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.

If faxed, this fax transmission contains information which is confidential and/or privileged. This information is intended for use only by the addressee indicated above. If you are not the intended recipient, please be advised that any disclosure, copying, distribution, or use of the contents of this information is strictly prohibited, and that any misdirected or improperly received information must be returned to this office immediately. Your cooperation in phoning us about an erroneous receipt is requested. Thank you.