Sun Pediatrics

NEW PATIENT REGISTRATION FORM

PATIENT'S PERSONAL INFORMATION

Name: _____ SSN: _____ DOB: _____ Sex: M or F

Address: _____

INSURANCE POLICY HOLDER (OR RESPONSIBLE PARTY IF UNINSURED) INFORMATION

Name: _____ Relationship to Patient: _____ SSN: _____

DOB: _____ Driver's License No: _____ State: _____

Address: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Employer: _____

Employer Address: _____

Occupation: _____ Work Phone: _____ O.K. to leave message at work? Y N

Primary Health Insurance Company: _____

ID/ Policy No: _____ Group Number: _____ Effective Date: _____

Secondary Health Insurance Company: _____

ID/ Policy No: _____ Group Number: _____ Effective Date: _____

ADDITIONAL FAMILY INFORMATION

Other Parents Name: _____ SSN: _____ DOB: _____

Employer: _____ Occupation: _____

Address: _____ Phone : _____

IN CASE OF EMERGENCY

Emergency Contact: _____

Relationship to Patient: _____ Home Phone: _____ Cell Phone: _____

PHARMACY INFORMATION

Address: _____ Phone : _____

Authorization to Pay Benefits to Sun Pediatrics:

I hereby authorize Sun Pediatrics to release any medical information needed to process insurance claims and authorize payments directly to Sun Pediatrics for all medical and surgical benefits. I agree that I am financially responsible on the day of service for any charges not covered by this authorization or not covered by my insurance policy(s).

Parent or Guardian Signature: _____ Date: _____