Sunnyside Pediatrics – Patient/Family Information Form

	First Child	Second Child	Third Child	Fourth Child
First Name				
Last Name				
Date of Birth				
Sex (M/F)				
Primary Language Spoken				
Ethnicity	___ Not Hispanic ___ Hispanic ___ Unknown	___ Not Hispanic ___ Hispanic ___ Unknown	___ Not Hispanic ___ Hispanic ___ Unknown	___ Not Hispanic ___ Hispanic ___ Unknown
Race (Check all that apply)	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander

Residence Address: _____ Primary Phone: (_____) _____ - _____

Primary Phone for child/children may be a "home" phone or a cell phone.

_____

Does this Residence Address and Primary Phone apply to all children shown? **Yes** **No** (Circle one. If No, provide necessary information here.)

IS YOUR INSURANCE THROUGH THE HEALTHCARE EXCHANGE? Y N

Who is the **Financial Guarantor** (person who receives billing statements)? _____

(Financial Guarantor must be included in Contacts on page 2.)

Primary Insurance – Please present card to be scanned

Policyholder's Full Name: _____ Policyholder's Date of Birth: _____/_____/_____

Insurance Plan Name: _____ Policyholder's Relationship to Patient: _____

Insurance ID Number:_____Effective Date of Plan: _____/_____/_____

Secondary Insurance – Please present card to be scanned

Policyholder's Full Name: _____ Policyholder's Date of Birth: _____/_____/_____

Insurance Plan Name: _____ Policyholder's Relationship to Patient: _____

Insurance ID Number:_____Effective Date of Plan: _____/_____/_____

Does this apply to all children? _____ (If no, provide other necessary information here.)

Parents

	First Contact	Second Contact
Full Name		
SSN		
Relationship to Patient(s)?		
Resides with Patient(s)?		
Street Address		
Address: City, State, Zip		
Birth Date		
Primary Phone: ("Home" phone)		
Work Phone:		
Cell Phone:		
Email: **Must be unique to Contact**		
Contact may have access to Patient Portal for all children? (Yes or No)		
Is this Contact preferred for reminders?		
Preferred method of Contact (Circle one preference for each reason)	**Appointment Reminders:** Primary Phone Text Email	**Appointment Reminders:** Primary Phone Text Email

- *If Patient is 18 or older, Include Contact Info for Patient. Please use another form if more Contact space is needed.*

Emergency Contact for listed children (other than Parents listed above):

Name _____ Relationship to Patient(s) _____ Phone (_____) ____-_____

Please list anyone else authorized to be your representative and bring your child(ren) to appointments:
I understand I can change or revoke the below authorization at any time but I can't change or revoke names given by another parent.

Name _____ Relationship to Patient(s) _____ Phone (_____) ____-_____

Name _____ Relationship to Patient(s) _____ Phone (_____) ____-_____

I have reviewed copies of the Financial Policy and Notice of Privacy, and these notices are available in the office and on our website. Copies are available upon request. I understand both biological parents have access to full disclosure (even if not the custodial parent) and both can authorize representatives unless parental rights have been terminated by court order. I understand if there are Custody Orders in place, I must present current copies for my child's file. I authorize the people listed to bring my child to any appointments in my absence and Sunnyside Pediatrics may call and leave a message regarding my child's clinical care, including lab and x-ray results in my absence. I understand this authorization for release of information will remain in effect until parent or guardian changes their disclosure with Sunnyside Pediatrics in writing. At that time this authorization will expire. I authorize Sunnyside Pediatrics, only upon my request, to fax any forms or immunizations records to my child's school. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers, my health insurance, my attorney, and/or other health practitioners. I authorize my insurance plan to make direct payment of medical benefits to Sunnyside Pediatrics. I understand Sunnyside Pediatrics provides immunization information to the Utah State Immunization Information System, and I may opt out of having my child's information sent by notifying Sunnyside Pediatrics in writing. In the event any balance is not paid as agreed, I agree to pay a collection fee equal to 35% of the unpaid balance. In the event of a lawsuit to collect any unpaid balance, I agree to pay all court costs and reasonable attorney's fees. Sunnyside Pediatrics reserves the right to charge $20.00 for no show/late cancellations. I understand that I am personally responsible for being aware of the dates and times of my scheduled appointments. I understand that it is my responsibility to choose the correct provider as my child's Primary Care Physician if my insurance company requires a PCP.

Signature _____ Relationship to Patient(s) _____ Date _____