Sunrise Family Clinic

# Registration Form (Pediatric)

**Patient's Full Name:** _____ **Previous Name(s):** _____

**Address:** _____

**Phone: Home** _____ **Cell** _____ **Work** _____ **Other** _____

**E-Mail Address:** _____ **Date of Birth:** _____

**Social Security Number:** _____-____ -_____ **Employer Name:** _____

**Please circle:**

**Sex:** M - F **Ethnicity:** Hispanic or Latino - Not Hispanic or Latino - Declined

**Race:** American Indian - Alaska Native - Asian - African American - White - Other _____ - Declined

**Preferred Language:** English - Spanish - Other _____

**Marital Status:** Married - Single - Divorced - Widowed - Legally Separated - Partner

**Employment Status:** Full-Time - Part-Time - Not Employed - Self-Employed - Retired - Active Military

**Student Status:** Full-Time Student - Part-Time Student - Not a Student

**Mother's Full Name:** _____ **Father's Full Name:** _____

**Custodial parent:** □ Mother □ Father □ Both □ Other _____

**Special instructions for patient information (if any):** _____

_____

***RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)***

□ Check here and skip to next section if information is same as patient

**Responsible Party Full Name:** _____ **Date of Birth:** _____

**Social Security Number:** _____-____ -_____ **Employer Name:** _____

**Address:** _____

**Phone: Home** _____ **Cell** _____ **Work** _____ **Other** _____

**E-Mail Address:** _____ **Date of Birth:** _____

Sunrise Family Clinic

# Registration Form, p2

Name: _____

***EMERGENCY CONTACT INFORMATION***

**Emergency Contact Name: _____ Relationship: _____**

**Phone: Home _____ Cell _____ Work _____ Other _____**

Do you have a living will, advanced directive, or healthcare power of attorney? Yes - No

*If yes, please provide us with a copy to keep in your file.*

**INSURANCE INFORMATION**: **You must present your insurance card(s) to the front desk at check-in.**

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I understand that I, the undersigned patient and/or guarantor am responsible for charges incurred. It is a courtesy for Sunrise Family Clinic (SFC) to file my insurance, and I am responsible for my copay and/or percentage, and in the event my insurance company does not pay, I am responsible for the balance due. It is also my responsibility to be aware of or call my insurance regarding their requirements for prior authorizations or referrals. If these are not obtained before the visit, I am liable for any charges. If SFC is unable to obtain payment within a reasonable amount of time from the patient and/or guarantor, SFC reserves the right to place your account with a collection agency, which will leave me liable for additional expenses incurred if applicable. I have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to Sunrise Family Clinic. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits.

_____ _____

Patient or Responsible Party Signature Date