

Sunrise Pediatrics
Patient Registration Form
(all fields are required to be completed in full)

PATIENT'S DEMOGRAPHICS

Patient Name: _____
(Last) (First) (Middle)

DOB: _____ Male Female Preferred Name: _____

Address: _____
(Street/PO Box) (City/State) (Zip Code)

Patient Cell (if patient is 18+): _____

Ethnicity: Hispanic Non-Hispanic Unknown Race(s): _____ Decline to Specify

Language: English Spanish Other

MINOR PATIENT'S PARENT/LEGAL GUARDIAN INFORMATION

**Step-parents must be listed on page 3 as authorized persons to treat patient.*

MOTHER'S INFORMATION:

Name: _____ DOB: _____

Phone: _____ OK to receive calls/texts? YES NO

Address: Same as Patient's Different than Patient's (please list below)

(Street/PO Box) (City/State) (Zip Code)

FATHER'S INFORMATION:

Name: _____ DOB: _____

Phone: _____ OK to receive calls/texts? YES NO

Address: Same as Patient's Different than Patient's (please list below)

(Street/PO Box) (City/State) (Zip Code)

PATIENT PORTAL

Email to be used for Patient Portal: _____

Sunrise Pediatrics strongly recommends usage of the patient portal. By utilizing this tool, you are able to:

- Submit appointment requests
- View lab/DI results, visit summaries and immunization records
- Send messages to the nurse or administrative staff

**Please note: Only one e-mail address can be associated w/ each patient's portal account. You may use the same e-mail for multiple children. Sunrise Pediatrics will NEVER use the Patient Portal for things unrelated to your child's health/medical record.*

I do NOT wish to enroll in the patient portal.

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RELEASE OF INFORMATION

Please list any additional person(s) who have permission to schedule, bring in and have access to medical and/or financial information for the dates they accompany the patient.

**Please note: we cannot deny a legal parent access without an official court order in the patient's chart.*

Name: _____ Phone Number: _____

Relationship: Parent/Step Parent Grandparent Aunt/Uncle Sibling (18+) Other: _____

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Name: _____ Phone Number: _____

Relationship: Parent/Step Parent Grandparent Aunt/Uncle Sibling (18+) Other: _____

I do **NOT** wish to authorize any additional person(s) permission.

PHOTO & VIDEO CONSENT

At *Sunrise Pediatrics*, we sometimes take photos and/or videos during office visits, community events or special activities to celebrate our patients and share our story. These may be used for educational, marketing or promotional purposes such as:

- Our website and social media pages
- Educational handouts and presentations
- Printed materials (flyers, posters, newsletters)
- Local media coverage of events

We value your child's privacy and will never share photos or videos that are inappropriate or violate confidentiality. Names and identifying information will not be shared unless you specifically authorize us to do so.

Please choose one of the following and complete the fields below.

I give permission for *Sunrise Pediatrics* to take and use photographs, videos or digital images of my child for the purposes listed above. I understand these may be used without further notice and I will not receive compensation.

I do NOT give permission for *Sunrise Pediatrics* to take or use photographs, videos or digital images of my child.

Patient's Name: _____

Parent/Guardian Name: _____
(please print)

Parent/Guardian Signature: _____

Date: _____

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PLEASE READ CAREFULLY AND INITIAL

_____ I understand the above release will stay in effect until a change is requested in writing.

_____ I understand that BOTH biological parents have access to full disclosure (including non-custodial parent) and both can authorize representatives unless parental rights have been terminated by court order. If those court orders exist, I understand I am required to present current copies for my child's file.

_____ I have reviewed and agreed to the Financial Policy, which states that I am financially responsible for any balance not covered by my insurance carrier. I understand that my coverage is determined by an agreement I have made with my insurance carrier and that insurance denials do not reflect the opinions of *Sunrise Pediatrics*.

_____ I understand that if my child has sick symptoms during a wellness exam, a separate visit charge may be billed and copayments and/or deductibles may apply, as determined by my insurance plan.

_____ I understand that my insurance card and a photo ID are required at the time of check-in for my child's appointment, along with any copayment and/or past due balance on my child's account.

_____ I understand that a fee of \$25 may be assessed for missed appointments and dismissal from the clinic may be considered for high missed appointment volume, as per *Sunrise Pediatrics* office policy.

_____ I have read and agree with the policies of *Sunrise Pediatrics*. I consent to the treatment of my child as well as the use and disclosure of my child's PHI (Protected Health Information) to carry out TPO (Third Party Operations) as outlined in our office Privacy Policy. I attest the information I have provided is true and correct.

PLEASE SIGN AND DATE BELOW

Signature of Parent/Legal Guardian: _____

Date: _____