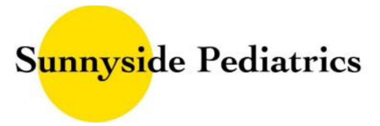

Patient Registration

Child's Legal Last Name: ______________________Legal First Name: ___________________________MI: _________

DOB: _____________Assign Sex at Birth: _______Preferred Pronoun/s: ___________Primary Language: _____________

Ethnicity: Hispanic or Latino, Non-Hispanic or Latino, Unknown, Decline to Specify

Race(s): Native American, Black, Asian, White, Pacific Islander, Decline to Specify, Other Race

Residence Address:

____

(Street or PO Box) (City) (State & Zip)

Other Sibling/s Name: ____

Primary Phone: (____) ______-________

Primary Contact (Will Receive Statements)

Name: ____ Relation to Patient: _______________________

Date of Birth: ________________ Lives with Patient? Yes / No

Primary Phone: (____)-____-______ Work Phone: (____)-____-______

Email: _______________________________________

How would you Ideally prefer to be contacted regarding (circle one):

Medical Issues: Primary Phone / Email

Appointment Reminders: Primary Phone / Text / Email

Recall Notices: Home Address / Primary Phone / Email

General Practice Notice: Home Address / Primary Phone / Email

Patient Portal Notifications: Email _______________________

Secondary Contact

Name: ____ Relation to Patient: _______________________

Date of Birth: ________________ Lives with Patient? Yes / No

Primary Phone: (____)-____-______ Work Phone: (____)-____-______

Email: _______________________________________

Emergency Contact **(Other than parent/s or guardian/s)**

Name: ____________________________Phone: (____)-____-______ Relation to patient: ____________

Name: ____________________________Phone: (____)-____-______ Relation to patient: ____________

Name: ____________________________Phone: (____)-____-______ Relation to patient: ____________

If parents are divorced or separated, please fill out this section:

Who has Custody? ____

are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or form obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that support this restriction.

____

I have reviewed copies of the Finical Policy and Notice of Privacy, and these notices are available in the office and our website. Copies are available upon request. 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 of guardian changes their disclosure with Sunnyside Pediatrics in writing. At that time this authorization will expire. I authorize the provider 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 cost 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 child's 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: __________________ Date: ___________