Patient Registration Form

Today's date:	Previous PCP (if any):

PATIENT INFORMATION					
Patient's Full Name (First, MI, Last, Suffix):			Date of Birth:	Social Security #:	
Ethnicity? ☐ Hispanic ☐ Non-Hispanic	Race:	Nickname:		Age:	Sex: ☐ M ☐ F
Street address:				Home phone #:	
City:			State:	ZIP Code:	
Grade:	School:			Preferred Language:	

How did you find us? Please check one:

☐Insurance Plan ☐ Google ☐ Referred by:__________________
☐ Family: _____________ ☐ Friend:________________ ☐ Close to home
☐ Other: ______________

Siblings (names and birthdates):
#1: ____
#2: ____
#3: ____

EMERGENCY CONTACTS (OTHER THAN PARENTS):			
#1: Name (First, Last):	Relationship to patient:	Mobile Number:	
Address, City/State and ZIP:			Home phone number:
#2: Name (First, Last):	Relationship to patient:	Mobile Number:	
Address, City/State and ZIP:			Home phone number:

INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Is this patient covered by insurance? ☐ Yes ☐ No (Self-Pay)				
Responsible Party:	Birth date:	Address:		Home phone:
Occupation:	Employer:	Employer address:		Employer phone:
Name of Primary Insurance Company:				
Subscriber's name:		Birth date:	Group #:	Policy #:

Patient's relationship to subscriber:	☐ Self ☐ Child ☐ Other		
Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:
Patient's relationship to subscriber:	☐ Self ☐ Child ☐ Other		

PHARMACY INFORMATION		
Pharmacy Name:	Address:	Telephone Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sunny Pediatrics and Family Medicine or insurance company to release any information required to process my claims.

I give permission for Sunny Pediatrics and Family Medicine to contact me via e-mail and/or text message.

Patient/Guardian signature

Date

Authorization for Release of Medical Information

Patient Name: ______________________________
DOB: ______________________________

I, ______________________________, hereby authorize the release of medical information

TO: Sunny Pediatrics and Family Medicine
5820 N. Canton Center Rd. Suite 186
Canton, MI, 48187
734.720.0976 (office) 734.201.1224 (fax)

FROM:
Doctor/Clinic/Hospital: ______________________________

Address: ______________________________

____

Telephone: ______________________________ Fax : ______________________________

Please release the following:
____ **All health information (including growth charts and vaccination records)**
____ History/Physical Exam
____ Progress Notes
____ Discharge Summary
____ Consultation Reports
____ Diagnostic Test Reports
____ Radiology/Images
____ Lab Results
____ Pathology Reports
____ Other (specify): ______________________________

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases, and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records.

____ Yes, I consent to the release of this information.
____ No, I do not consent to the release of this information.

Purpose of disclosure:
____ Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: ______________________________ Date: ______________________________

Print Name: ______________________________

Relationship to Patient: ______________________________