SUNNY
PEDIATRICS &
FAMILY MEDICINE

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:

FAMILY/CONTACT INFORMATION	
Patient resides primarily with: ☐ Both Parents ☐ Mother ☐Father ☐Legal Guardian: _____ ☐Other: _____ Parents are: ☐ Married ☐ Divorced ☐Separated ☐Other: _____	
Mother's Name and Birth Date:	Home phone number:
Mobile number:	E-mail:
Occupation:	Employer & Work Number:
The best way to reach me is: ☐ Home Number ☐ Mobile Number ☐ E-mail	
Father's Name and Birth Date:	Home phone number:
Mobile Number:	E-mail:
Occupation:	Employer & Work Number:
The best way to reach me is: ☐ Home Number ☐ Mobile Number ☐ E-mail	

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
___ Other (specify): _____
___ Diagnostic Test Reports
___ Radiology/Images
___ Lab Results
___ Pathology Reports

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:_____

Consent To Treat Minor

I hereby give consent to Sunny Pediatrics and Family Medicine to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician, as well as any medical assistant or nurse practitioner, on the staff of Sunny Pediatrics and Family Medicine to the below named minor(s).

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required.

This consent is given to any and all such diagnoses, treatments, and hospital care which a licensed physician at Sunny Pediatrics and Family Medicine recommends.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Minor #1: Name _____ Date of Birth _____

Minor #2: Name _____ Date of Birth _____

Minor #3: Name _____ Date of Birth _____

Minor #4: Name _____ Date of Birth _____

Minor #5: Name _____ Date of Birth _____

Signed: _____

Print Name: _____

Date: _____

Please specify relationship to minor:

- ☐ Parent with legal custody
- ☐ Guardian with legal custody

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