

1 Randall Square Suite 404 Providence, RI 02904 Phone: (401) 861-5183 Fax: (401)-861-5276 sunshinepediatricsri.com

Welcome to Sunshine Pediatrics! We are glad that you have chosen us to provide your child's primary care, and we are looking forward to working with your family.

Enclosed you will find our new patient information. Please complete the new patient forms and fax them to 401-861-5276 or bring them with you to your first appointment. Please **do NOT** email us any completed forms.

#### Required

- **Family Demographic Form:** This form provides your address and phone number, emergency contacts, and insurance information. Only one form needs to be completed per household.
- Release of Records: It is important that we obtain copies of your child's previous medical records from those who have treated your child in the past. Please complete a separate release form for each doctor your child has seen
- **Update Insurance Provider:** It is also important that you contact your insurance company and alert it that Sunshine Pediatrics will be serving as your child's primary care physician. Also, please be sure to bring your insurance card(s) and required co-payment (if any) to the appointment.

## Optional

• **Patient Portal:** The Patient Portal is a way for you to access information about your visits, health records, and even check into your next appointment. In order to access the Patient Portal, please request a username and password from the front desk.

#### **Our hours**

#### **Sunshine Pediatrics Office Hours**

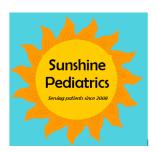
| Monday      | Tuesday     | Wednesday   | Thursday    | Friday      | Saturday | Sunday        |
|-------------|-------------|-------------|-------------|-------------|----------|---------------|
| 9 AM – 6 PM | 9 AM – 5 PM | 9 AM – 5 PM | 9 AM - 5 PM | 9 AM – 5 PM | 9AM-12PM | Office Closed |

#### Office Policies

- **No show visits:** There will be a \$50-100 charge for no show visits if not cancelled 24 hours prior to the appointment.
- **Refill Requests:** Requests for refills can be made through the patient portal, or by calling the office and leaving a voice message.
- Call service: Call service is available after hours and all-day on Sundays. You can use the call service to get in
  contact with a Sunshine Pediatrics care provider for any urgent concerns. In the case of an emergency or
  what you suspect may be an emergency, please call 911 immediately. PLEASE DO NOT GO THE EMERGENCY
  ROOM UNLESS IT IS A REAL EMERGENCY

Once again, welcome to Sunshine Pediatrics. Should you have any questions, please do not hesitate to contact us at (401) 861 – 5183.

Warm Regards.



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|  |                    | Fai   | mily Demographic   | <u> </u>                      |  |
|--|--------------------|---|--|-------------------------------|--|
|  | Child              |   | Mother   | Father                        |  |
|  |                    |   | First:   | First:                        |  |
|  |                    |   | Middle:  |                               |  |
|  |                    |   | Last:  |                               |  |
|  |                    |   |  | _                             |  |
| Email address  |                    |   |  | l                             |  |
| Birthdate  | 1 1                |   | 1 1  | 1 1                           |  |
| Sex  | Female ( ) Ma      | ale ( )   |  |                               |  |
| Full Address   | Street:            |   | ( ) same   | ( ) same                      |  |
|  | City:<br>State: Zi | p:  |  |                               |  |
| Social Security #  |                    |   |  |                               |  |
| Phone Number   |                    |   |  |                               |  |
| Place of employment  |                    |   |  |                               |  |
| Work Phone Number  |                    |   |  |                               |  |
|  |                    |   |  |                               |  |
| Patient Information:   |                    | <b>,</b>  |  |                               |  |
| Language   |                    | Race  |  | Ethnicity                     |  |
| () English () Spa  | nish               | ( ) American Indian or                          | Alaska Native  | () Hispanic or Latino         |  |
| () Portuguese () Aral  | Dic                | () Asian  |  | ( ) Non- Hispanic or Latino   |  |
| ( ) Chinese ( ) Russian  |                    | () Black or African Am<br>() Native Hawaiian or |  | () Unknown                    |  |
|  |                    |   |  | ( ) Decline                   |  |
| Interpreter needed? ( ) Yes ( ) No ( ) Other ( ) Dec                                       |                    |   | ecime  |                               |  |
|  |                    |   | sented that proves otherwise   | !.                            |  |
| ,  |                    | •   | ·  |                               |  |
| How did you hear about   |                    |   |  |                               |  |
| () Family () Friend ()   | Close to home/     | work ( ) Insurance ( ) H                        | lospital ( ) Other   |                               |  |
| In case of an emergency  | , please list the  | name and phone numb                             | er two emergency contacts n  | ot currently living with you: |  |
| 1. Name  |                    |   | onship:  | Phone Number:                 |  |
|  |                    | nship: Phone Number:                            |  |                               |  |
| Insurance Information P  |                    | r insurance card to the r                       | -  |                               |  |
| Primary Insurance Name:  |                    |   | Secondary Insurance Nan  | ne:                           |  |
|  |                    |   |  |                               |  |
| Policy # Group #   |                    |   | Policy #   | Group #                       |  |
| Subscriber's Name:   |                    |   | Subscriber's Name:   |                               |  |
| Patient's relationship to  | o subscriber:      |   | Patient's relationship to s  | ubscriber:                    |  |
| ( ) Self ( ) Spouse ( ) Child ( ) Other  Subscriber's address (if different than patient): |                    |   | ( ) Self ( ) Spouse ( ) Child ( ) Other  Subscriber's address (if different than patient): |                               |  |
|  |                    |   |  |                               |  |
|  |                    |   |  |                               |  |
| Relationship to patient if   | r signature is no  | or patient:                                     |  | Date:                         |  |



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# **Notice of Privacy Practices**

See our website <u>www.sunshinepediatricsri.com/newpatientforms</u> for our notice of privacy practices, or ask the front desk for a copy of our Privacy Practices Notice.

The above information in the Family Demographic Form is true to the best of my knowledge. I have received, understand, and agree to the financial and office policy and . I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any non-covered services, or any balances I am contractually obligated to pay as determined by my insurance plan. I also authorize Sunshine Pediatrics, and the insurance company, to release any information required to process my claims.

| Name :   | Patient/ guardian signature |
|--|-----------------------------|
| Relationship to patient if signature is not patient: |                             |
| Date:  |                             |



Date:

## **Sunshine Pediatrics**

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# **Medical History**

Patient Name: Patient Date of Birth:

| Birth History:  /as the child full term? ( ) Yes ( ) No What was the child's birth weight?  /ere there any problems with delivery?  |   |
|---|---|
| Medications lease list the name of the medication, the dosage (e.g. 5mg, 10mg), and the frequency you take it.  |   |
|   |   |
|   | _ |
|   |   |
|   |   |
|   |   |
| <u>Allergies</u>  |   |
| ease list all allergies.  | _ |
|   | _ |
|   |   |
|   |   |
|   | _ |
| as your child ever been hospitalized or ever undergone any surgeries? ( ) Yes ( ) No so, when, where, and for what reason? oes your child currently have, or have a history of any of the following symptoms? Please check all that apply: ) Asthma ( ) Diabetes ( ) Skin Problems ( ) Tuberculosis ( ) Seizures ) Problems with stool ( ) Ear infections ( ) Eye problems ) Heart Murmur ( ) Problems with urination ( ) Other illness |   |
| Family Medical History:   |   |
| lease check off any disease that the child's parents, grandparents, brothers, sisters, aunts, or uncles have had:  ) Anemia () Mental Illness () Asthma () Drug problems ) Allergies () Alcohol problems () Diabetes () Inherited illness ) Heart Trouble () Venereal disease () Cancer () Tuberculosis ) AIDS () Other   |   |
| Pharmacy information  |   |
| ny prescription we provide to you today will be sent electronically to your pharmacy of choice. Please list the pharmacy below. If there is nore pharmacy in your town, please be sure we have the correct street name.  Town of the pharmacy and street name:  |   |
| harmacy Telephone:  |   |
|   |   |
| ame:Patient/ guardian signature   |   |
| elationship to patient if signature is not patient:   |   |



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## **Financial & Office Policies**

**Insurance:** We accept most insurance plans. At each visit we verify your current insurance. If we are unable to verify insurance coverage, you will be expected to pay at the time of service. It is your responsibility to know your plan's benefits and coverage. Please contact your insurance company directly with any questions you may have regarding your plan.

Co-Payments and Deductibles: Co-payment and co-insurance are determined by your insurance. All co-payments must be paid at the time of service. A deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance begins to pay.

**Treatment of Minors:** Patients under the age of 18 must be accompanied by a parent or guardian to their first appointment. To provide treatment to a minor under the age of 16 without the presence of a parent or guardian during subsequent visits, a signed consent form must be on file. All copays or monies due are expected to be paid at the time of each service. Patients above the age of 16 can be seen alone for subsequent visits.

**Non-Payment and Returned Checks:** We understand that temporary financial problems may affect the timely payment of your balance. Please communicate your situation with the front desk so that we can assist you in the management of your account. There will be a \$25 charge for checks returned for insufficient funds.

By signing below, I acknowledge I have read, understand, and agree with the above policies and statements, and that all my questions have been answered in a language that I understand.

| Print Patient's Name:                                  | Date: |  |
|--|-------|--|
| Patient/ Guardian Signature:                           |       |  |
| Relationship to patient (if signature is not patient): |       |  |



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# **No Show Policy**

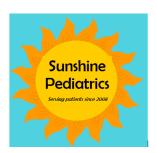
We understand that unforeseen circumstances can occur at the last minute. However, please understand that when we schedule your appointment, we are reserving a time for your particular needs. The office does make multiple attempts to confirm your appointment in advance.

Your time is valuable, as is that of all families served by this practice. We kindly ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient who would like it. Missing a physical exam will result in limited scheduling options.

Failure to adhere to this policy will result in a charge of \$50-\$100 billed to you.

We look forward to continuing to provide high quality care for your child.

| Thank you,          |
|---------------------|
| Sunshine Pediatrics |
| Patient Name:       |
| Date of Birth:      |
| Signature:          |
| Print Name:         |
| Date:               |



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# Authorization for release of confidential information

| Patient name:  | DOB:   | Phone number:  | ·   |
|--|--|--|---|
| Address:   |  |  |   |
| I authorize Sunshine Pediatrics:   |  |  |   |
| ( ) To release my medical record   |  |  |   |
| to:address:  |  | Fax  |   |
| ( ) Obtain my medical record from:<br>Address:   |  |  |   |
| Tel:   |  |  |   |
| Fax:   |  |  |   |
| Check confidential information to be released of   | or obtained:   | Entire Record  |   |
| Problem list Immunization record M Prenatal record Laboratory results fr X- ray and imaging reports from (date) Progress notes from (date) to (dotte)  | rom: (date)<br>to (date)   | to: (date)   | -   |
| <ol> <li>To the extent applicable, I understand to under law. My check mark(s) below inderleased. I understand that if I do not cleabout me if it exists.         HIV/ AIDS infection         Mental health     </li> <li>I understand that my records are protefor finder land and cannot be disclosed. I understand that if the person(s) or encovered by federal privacy regulations, protected by those regulations. Therefor liability arising from this disclosure of mental such or interest in the person into the subject to my information would not be subject to my</li> </ol> | that my medical record licate (s) that I DO NOT heck the box, Sunshine Sexually transited under the federal divithout my written outity(s) that receives the information descriptore, I release Sunshine my health information. zation will expire 90 doin writing, Sunshine Pedicate (s) that receives the information descriptore, I release Sunshine my health information. | d may contain information the PERMIT information of this Pediatrics will release and/mitted diseases ment for alcohol and/ or drug privacy laws and regulation consent except as otherwise information is not a health libed above may be re – disclared pediatrics, its employees are as the laws from the date signed be | nat is considered sensitive is type. If it exists, to be for obtain such information g abuse is and under the General laws a specifically provided by law is care provider or health plant losed and is no longer and my physician(s) from all low. I understand that I may |
| This form must be completed in full <u>before</u> signi  | ing:   |  |   |
| Signature of patient or patient's legal represent  | rative Date  | Print pati   | ent's name  |
| Print name of legal representative (if applicable  | ) Relation   | ship to parent   | _   |