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

	Child	Mother	Father
Full Name	First: _____ Middle : _____ Last: _____	First: _____ Middle : _____ Last: _____	First: _____ Middle : _____ Last: _____
Email address			
Birthdate	/ /	/ /	/ /
Sex	Female ( ) Male ( )		
Full Address	Street: City: State: Zip:	( ) same	( ) same
Social Security #			
Phone Number			
Authorization to text?	( ) yes ( ) no		
Place of employment			
Work Phone Number			

Patient Information:

Language	Race	Ethnicity
( ) English ( ) Spanish ( ) Portuguese ( ) Arabic ( ) Chinese ( ) Russian ( ) Other :	( ) American Indian or Alaska Native ( ) Asian ( ) Black or African American ( ) Native Hawaiian or Pacific Islander ( ) White ( ) Decline ( ) Other	( ) Hispanic or Latino ( ) Non- Hispanic or Latino ( ) Unknown ( ) Decline

Interpreter needed? ( ) Yes ( ) No

Custody: Joint custody is assumed unless documentation is presented that proves otherwise.

How did you hear about Sunshine Pediatrics?
( ) Family ( ) Friend ( ) Close to home/work ( ) Insurance ( ) Hospital ( ) Other
In case of an emergency, please list the name and phone number two emergency contacts not currently living with you:

1. Name: Relationship: Phone Number:
2. Name: Relationship: Phone Number:

Insurance Information Please give your insurance card to the receptionist:

Primary Insurance Name:	Secondary Insurance Name:
Policy # Group #	Policy # Group #
Subscriber's Name:	Subscriber's Name:
Patient's relationship to subscriber: ( ) Self ( ) Spouse ( ) Child ( ) Other	Patient's relationship to subscriber: ( ) Self ( ) Spouse ( ) Child ( ) Other
Subscriber's address (if different than patient):	Subscriber's address (if different than patient):

Name: _____Patient/ guardian signature _____

Relationship to patient if signature is not patient: _____Date:_____

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Notice of Privacy Practices
Please see here for our notice of privacy practices, or ask the front desk for a copy of our Privacy Practices Notice.

The above information is true to the best of my knowledge. I have received, understand, and agree to the financial policy. 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, or 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:

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Medical History

Patient Name: Patient Date of Birth:

Birth History:

Was the child full term? ( ) Yes ( ) No What was the child's birth weight? _____
Were there any problems with delivery? _____

Medications

Please list the name of the medication, the dosage (e.g. 5mg, 10mg), and the frequency you take it.

Allergies

Please list all allergies.

Past Medical History

Has your child ever been hospitalized or ever undergone any surgeries? ( ) Yes ( ) No
If so, when, where, and for what reason? _____
Does 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 ( ) Food problems
( ) Heart Murmur ( ) Problems with urination ( ) Other illness _____

Does your child take any medication regularly? ( ) Yes ( ) No
If yes, please list medications: _____
_____
_____

Family Medical History:

Please 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

Any prescription we provide to you today will be sent electronically to your pharmacy of choice. Please list the pharmacy below. If there is more pharmacy in your town, please be sure we have the correct street name.
Pharmacy Name: **Town of the pharmacy and street name:**

Pharmacy Telephone:

Name: _____Patient/ guardian signature _____

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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 as 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:_____
( ) Obtain my medical record from: _____
Address: _____
Telephone Number:_____
Fax Number:_____
Check confidential information to be released or obtained:
___ Problem list ___ Immunization record ___ Most recent history and physical
___ Prenatal record ___ Laboratory results from: (date) _____ to: (date) _____
___ X- ray and imaging reports from (date) _____ to (date) _____
___ Progress notes from (date) _____ to (date) _____
___ other_____ ___ Entire Record
The purpose of this information is for ___ transfer ___ continuity of care ___ attorney
___ insurance ____ Other_____

1. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under law. My check mark(s) below indicate (s) that **I DO NOT PERMIT** information of this type. If it exists, to be released. I understand that if I do not check the box, Sunshine Pediatrics **will** release and/or obtain such information about me if it exists.
   ___ HIV/ AIDS infection ___ Sexually transmitted diseases
   ___ Mental health ___ treatment for alcohol and/ or drug abuse
2. I understand that my records are protected under the federal privacy laws and regulations and under the General laws of Rhode Island and cannot be disclosed without my written consent except as otherwise specifically provided by law.
3. I understand that if the person(s) or entity(s) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re – disclosed and is no longer protected by those regulations. Therefore, I release Sunshine Pediatrics, its employees and my physician(s) from all liability arising from this disclosure of my health information.
4. It is my understanding that this authorization will expire 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, Sunshine Pediatrics. I understand that any previously disclosed information would not be subject to my revocation request.

This form must be completed in full before signing:

_____ _____ _____
Signature of patient or patient's legal representative Date Print patient's name

_____ _____
Print name of legal representative (if applicable) Relationship to parent