Sunshine Pediatrics of Lutz

Bringing Sunny Smiles To Children From 0-21 Years

New Patient Registration

Patient Information

Legal First Name: ____________________ MI:______ Legal Last Name: ____________________

Nickname: ____________________DOB:________________ Patient SSN: ____________________

Ethnicity (circle one) Caucasian African American Hispanic/Latino Asian American Indian/Alaskan Other

Home Address: ____

City: __________________ State:__________________ Zip code: ________________

Email address: ________________________________Telephone Number: ____________________

Emergency Contact Name: ______________________ Emergency Contact Phone Number:______________

Siblings: (name, age, sex): ____

Are Parents: (circle one): Married Separated Divorced Single Widowed

Preferred Pharmacy Name and Phone Number: ____

Insurance Information

Primary Insurance Name:________________________ Policy Number: ________________________

Group Number:______________________________ Insurance Phone Number:__________________

Policy Holder's Name: __________________________ Policy Holder's DOB:____________________

Parent/Guardian Information

Mother's Legal First and Last Name: ______________________________ DOB:________________

Mother's SSN:________________________ Telephone Number:____________________________

Address: ____

Occupation: ____________________ Employer Name and Phone:____________________________

Father's Legal First and Last Name: ______________________________ DOB:________________

Father's SSN:________________________ Telephone Number:____________________________

Address: ____

Occupation: ____________________________ Employer Name and Phone:____

Who May We Thank for Referring you to Our Practice? ____

By signing below, I have agreed to the following:

1. **To pay in full, at the time of service, all medical services rendered by Sunshine Pediatrics of Lutz as they are received by me, my spouse, or my dependents.**
2. **I hereby authorize the release of medical information for review and process claim.**
3. **I hereby authorize any insurance company to pay the proceeds of my benefits directly to Sunshine Pediatrics of Lutz.**
4. **A copy of this agreement can be considered as an original for Medicaid and Insurance purposes.**

Print Name:____ Date:______________________________

Sign Name:____ Date:______________________________