sunrise pediatrics & adolescent center

NEW PATIENT INFORMATION

Patient Information:

Name: _____ Nickname: _____
Date of Birth: _____ Sex: Male Female
Address: _____ City: _____ State: _____ zip code: _____
Home Phone: (_____) _____ - _____ Email: _____
How did you hear about our clinic: _____

Parents/Guardians:

Mother: _____
DOB: _____ CELL# _____
Father: _____
DOB: _____ CELL# _____
Married Divorced Widowed Never Married

1.Insurance Information:

Subscriber Name: _____
SSN: _____ Policy#: _____
Company: _____
Group#: _____ Co pay: _____

2.Insurance Information:

Subscriber Name: _____
SSN: _____ Policy#: _____
Company: _____
Group#: _____ Co pay: _____

BIRTH HISTORY:

Born @ _____ weeks
Hospital: _____ Type of delivery: _____
Complications: _____
Birth Weight: _____ Birth Length: _____
Did baby have any problems at birth? _____
_____

HEALTH HISTORY:

Date of last physical examination: _____
Is child on any medication or drugs? _____
Has your child been hospitalized? _____
Allergies to medication? _____

SOCIAL HISTORY:

Check all that apply

Pets____ Smoking____ Siblings____

FAMILY HISTORY:

Has any of the family or close relative had:

- ☐ Arthritis
- ☐ Asthma or Hay fever
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Convulsion or epilepsy
- ☐ Diabetes
- ☐ Heart disease
- ☐ Hemophilia-bleeder
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Mental disorders
- ☐ Migraine s
- ☐ Tuberculosi
- ☐ Other: _____

Has minor/child had any history of or difficulty with any of the following:

- ☐ A.I.D.S / HIV
- ☐ Anemia
- ☐ Asthma
- ☐ Bed wetting
- ☐ Birth defects
- ☐ Blader problems
- ☐ Bleeding excesive
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ Chicken pox
- ☐ Constipation
- ☐ Diarrhea
- ☐ Convulsions
- ☐ Diabetes
- ☐ Drug/alcohol abuse
- ☐ Ear infections
- ☐ Epilepsy
- ☐ Fainting
- ☐ Hearing problems
- ☐ Heart problems
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Lead poisoning
- ☐ Liver disease
- ☐ Measles
- ☐ Mumps
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Speech problems
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Urinary Diseases
- ☐ Vision problems
- ☐ Worms
- ☐ Other:

RELEASE AND ASSIGNMENT

The information I have given you is correct to the best of my knowledge.
I understand that it will be held in the strictest of confidence, and is my responsability to inform this office of any changes in my minor-child's medical status.
I certify that my minor/child is cover by insurance with _____
And assigned directly to *SUNRISE PEDIATRICS & ADOLESCENT CENTER* all insurance benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits.
I Authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Parent / Guardian _____ Date: _____

Sunrise Pediatrics & Adolescent Center

Please read and sign before turning in paper.

NOTICE OF PRIVACY PRATICES ACKNOWLEDGEMENT

I, _____parent or legal guardian of _____, acknowledge that I have receive and reviewed the Notice of Privacy Practice used by Sunrise Pediatrics & Adolescent Center. I also acknowledge that I understand how medical information about my child and family may be used by Sunrise Pediatrics to provide medical treatment and to coordinate treatment for my child.

Signature_____Date_____

CONSENT FOR TREATMENT

Sunrise Pediatrics & Adolescent clinic provides primary healthcare including the diagnosis and treatment of illness or injuries to your child. Services at our practice are provided by Dolores Ifezue and Sunrise Pediatrics Staff. The undersigned, having read and expressed understanding of this document by the signature below, does hereby agree to be medically attended and treated by Sunrise Pediatrics

Signature_____Date_____

APPOINTMENT OF AGENT

I, _____, hereby appoint the following persons of lawful age as my agent or representative for the purpose of authorizing and consenting to medical care and treatment of _____ for any illness or injury that may occur while such person is in the care or custody of the agent while I am away or not available to give such consent.

_____ _____

_____ _____

Signature _____Date_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of information from the medical records of:
Yo doy la autorization de relizar la information medica de:

Patient Name/ Nombre del Patiente — Date of Birth/ Fecha de Nacimiento

Address/Direccion — Phone Number/ Telefono

From / De:

Name of Previous Clinic/ Nombre De La Clinica Anterior

Address/ Direccion — Phone Number/Telefono

To be released to:

Sunrise Pediatrics & Adolescent Center
Dr. Dolores Ifezue
1201 19th Street
Plano, TX 75074
Ph. (972)-424-5437 Fax (972)-424-5438
***PLEASE MAIL MEDICAL RECORDS**
If more than 25 pages

Please release the following:

__All medical records
__Labs/x-rays/EKG report
__Summary sheet only
__Including information relating to HIV/AIDS, Psychiatric Disorder or Drug Abuse.
__Immunization records only (**URGENT FAX ASAP**)
__ OTHER_____

I understand that the information released is for the specific purpose designated above, and this consent expires in 365 days after the date of my signature. The facility and doctor are hereby released and discharge from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Signature/Firma — Date/ Fecha

NOTICE TO AGENCY RECEIVING THIS INFORMATION: This information has been disclosed to you from a records whose confidentiality is protected, Statutes and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.