NEW PATIENT/ NEW BORN INFORMATION SHEET

PATIENT'S NAME____________________________ **SS#**________________ **BIRTH DATE**_____________
MAILING PLEASE PRINT
ADDRESS____ **PHONE#**_______________
STREET (P.O. BOX) APT # CITY STATE ZIP CODE

MALE or FEMALE **RACE: WHITE or BLACK or HISPANIC or OTHER** _______________

FATHER'S NAME_______________________________________ **SS#**______________ **D.O.B.**___________
MAILING PLEASE PRINT
ADDRESS____ **PHONE#**______________
STREET (P.O. BOX) APT # CITY STATE ZIP CODE
FATHER'S EMPLOYER__________________________ **WK PH#**____________ **CELL PH#**____________

MOTHER'S NAME_______________________________________ **SS#**_____________ **D.O.B.**___________
MAILING PLEASE PRINT
ADDRESS____ **PHONE#**______________
STREET (P.O. BOX) APT # CITY STATE ZIP CODE
MOTHER'S EMPLOYER__________________________ **WK PH#**___________ **CELL PH#**_____________

LIST OF BROTHERS & SISTERS (WITH AGES):
____
____
____

PARENTS: (CIRCLE ONE) **MARRIED** **SEPARATED** **DIVORCED** **SINGLE**

IN CASE OF EMERGENCY (OTHER THAN PARENT) NOTIFY:

NAME______________________________ **RELATIONSHIP**________________ **PHONE#**______________

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE DIRECT PAYMENT OF SURGICAL/ MEDICAL BENEFITS TO SUNRISE PEDIATRICS FOR SERVICES RENDERED BY THE DOCTORS IN PERSON OR UNDER THE DOCTORS' SUPERVISION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE. OCCASIONALLY, A NEW IMMUNIZATION, TREATMENT, OR SCREENING SUCH AS A HEARING TEST, TYMPANOGRAM OR VISION SCREEN IS NOT COVERED BY YOUR INSURANCE COMPANY. THERE IS NO WAY THAT WE CAN BE SURE WHAT EACH INSURANCE COMPANY MAY OR MAY NOT COVER, ESPECIALLY NEWER RECOMMENDATIONS, SUCH AS THE LATEST VACCINE.

I HEREBY AUTHORIZE SUNRISE PEDIATRICS TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN MY PROCESSING APPLICATIONS FOR FINANCIAL BENEFIT.

PATIENT NAME (PRINT)____ **DATE**____________________
GUARDIAN (PRINT)________________________________ **SIGNATURE**____________________________

PREGNANCY & BIRTH

MOTHER'S AGE AT PREGNANCY__________________
PROBLEMS WITH PREGNANCY____
SMOKING, ALCOHOL, OR STREET DRUGS DURING PREGNANCY_______________________________________
BABY WAS: EARLY / ON TIME / LATE (CIRCLE ONE) **DELIVERY: VAGINAL / C-SECTION**
BIRTH WEIGHT_______________**LBS**____________**OZ** **BIRTH LENGTH**________________
COMPLICATIONS YES / NO (CIRCLE ONE) **IF YES, WHAT TYPE**_________________________
____

CHILD'S MEDICAL HISTORY

PREVIOUS **M.D.'S NAME**__________________________ **SHOTS UP TO DATE: YES / NO** (CIRCLE ONE)
ALLERGIES____
MEDICATIONS (TAKEN ON A REGULAR BASIS)____
HOSPITALIZATIONS (WHEN, WHERE, WHY)____

SERIOUS INJURIES(WHEN)____

DISEASES: (CIRCLE IF HAS/ HAD)

RED MEASLES *WHOOPING COUGH* *SCARLET FEVER* **RECURRENT INFECTIONS:**
CHICKEN POX *HEPATITIS* ______ *ECZEMA/HIVES* *EAR(S) / THROAT*
ASTHMA/ WHEEZING *SEIZURES* *GERMAN(3 DAY)MEASLES* **PROBLEMS W/:**
*OTHER*________________ *ANEMIA* *MUMPS* *RHEUMATIC FEVER* *HEARING / VISION*