Always Sunny Pediatrics
Patient Registration

Patient Information: Sex

Last _____ First _____ Middle _____ ☐ Male ☐ Fem

Address _____ ☐ Trans M to F

Birthdate _____ Phone: _____ ☐ mother ☐ father ☐ patient ☐ other ☐ Trans F to M

Race ☐ White ☐ African American. ☐ Am. Indian ☐ Alaskan Nat. ☐ Asian ☐ Nat. Hawaiian/Pacific Islander

Ethnicity ☐ Hispanic ☐ Non-Hispanic Preferred Language (if other than English): _____

Emergency Contact: Translator Required: ☐ Yes ☐ No

Name _____Phone _____ Relationship to patient _____

Parents/Guardian Information:

Mother/ Guardian Name: _____ Birthdate _____ Email _____

Address _____ City _____ State _____ Zip_____

Phone Home _____ Cell _____ Work _____ Email _____

Preferred method of contact ☐ Text Cell ☐ Call Cell ☐ Call Home ☐ Email ☐ Portal ☐ Mail

Father/ Guardian Name _____ Birthdate _____ Email _____

Address _____ City _____ State ____ Zip _____

Phone Home _____ Cell _____ Work _____ Email _____

Preferred method of contact ☐ Text Cell ☐ Call Cell ☐ Call Home ☐ Email ☐ Portal ☐ Mail

Insurance/Financial Information

Insurance _____ ID # _____ Group _____

Subscriber Name _____ Birthdate _____ Social Security _____

Relationship to Patient _____ Employer _____

Person financially responsible _____ Birthdate _____ Phone _____

Address _____

Siblings Same Parents Same address

Name _____ Date of Birth _____ Yes ☐ No ☐ Yes ☐ No ☐

Name _____ Date of Birth _____ Yes ☐ No ☐ Yes ☐ No ☐

Name _____ Date of Birth _____ Yes ☐ No ☐ Yes ☐ No ☐

Name _____ Date of Birth _____ Yes ☐ No ☐ Yes ☐ No ☐

List of Authorized Persons for Medical Purposes:

The individuals listed below are authorized to bring my child to appointments and consent for treatment, examinations, and vaccines in my absence. As a result, you should be aware that these individuals may acquire personal information during a visit.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I authorize necessary treatment for my child's care by the Always Sunny staff to be given with my verbal consent. I authorize payment by my insurance company directly to Always Sunny of the medical/surgical benefits for the services rendered and release of medical information to my health insurance to process claims and to specialists when referred for consults. I understand that I am financially responsible to AACPP for all payments due that are not covered by my insurance plan.

Signature: _____ Printed Name _____ Date _____