SUNSHINE VALLEY
PEDIATRICS

SUMMERLIN LOCATION
653 N. Town Center Drive, Ste. 106
Las Vegas, Nevada 89144
Phone: (702) 363-3000
Fax: (702) 363-3161

SOUTHWEST LOCATION
9091 W. Post Rd.
Las Vegas, NV 89148
Phone: (702) 363-3000
Fax: (702) 778-6821

PATIENT INFORMATION FORM

Patient's Last Name | First Name | MI | Sex (M / F)

Street Address | City | State | ZIP

Home Phone Number | Date of Birth | Age

□ American Indian □ Asian □ Declined
□ African American □ Pacific Islander □ Hispanic/Latino
□ Caucasian □ Other Race

Cell Phone Number

Parent/Guardian's Last Name | First Name | MI

Street Address | City | State | ZIP

Home Phone Number | Work Phone Number | Employer | Date of Birth | Marital Status

Relationship to Patient | Email Address | Social Security No.

Parent/Guardian's Last Name | First Name | MI

Street Address | City | State | ZIP

Home Phone Number | Work Phone Number | Employer | Date of Birth | Marital Status

Relationship to Patient | Email Address | Social Security No.

Primary Insured's Name and DOB (__/__/____) | Relationship to Patient | Social Security No.

Primary Insured's Home Address | City | State | ZIP

Primary Insurance Carrier | Policy # | Group #

Insurance Claims Address | City | State | ZIP

Preferred Pharmacy Name & Phone Number | Address | City | State | ZIP

Emergency Contact (OTHER THAN PARENT) | **Phone** | **Relationship to Patient**

PLEASE COMPLETE BOTH SIDES OF THIS FORM. THANK YOU.

Sibling Name	Date of Birth	Age
Sibling Name	Date of Birth	Age
Sibling Name	Date of Birth	Age

YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, REGARDLESS OF INSURANCE!

• You agree to pay all insurance co-pays at the time of check-in and prior to services being rendered and all deductibles and coinsurance at the time of check-out.

• If Sunshine Valley Pediatrics cannot verify your insurance at the time of visit, or if you do not bring current proof of insurance to each visit, you agree to pay charges in full before the patient can be seen.

• If any charges incurred by you or your dependents are submitted to a collection agency, you agree to pay all fees including, but not limited to, both the collection agency fee and the account balance. Once an account has gone to collections, we cannot waive the collection agency's fees.

• If you miss an appointment without 24-hour prior notification to this office, you agree to pay a $35.00 Charge.

• You agree to pay a $25.00 Charge, in addition to the check amount, on any of your personal checks which are returned to this office by our bank.

• While your appointment may be for a specific time, no express or implied guarantee is made that a nurse or physician will see you at that exact time. Sunshine Valley Pediatrics makes every effort to see patients in a timely fashion, subject to patient volume and emergencies beyond our control. You agree not to hold Sunshine Valley Pediatrics responsible in any manner for time spent waiting to be seen.

• You agree and understand that Sunshine Valley Pediatrics does not bill secondary insurance companies. Once your insurance claim is submitted we cannot change the reason for your visit.

• If your insurance has not paid this office within 90 days, you agree to pay all charges which have been incurred by you or your dependents at the time of visit, regardless of your insurance company's instructions.

• As the child's parent, I understand that it is my responsibility to make and attend all follow-up visits ordered by the doctor. I understand that the doctor would not order a follow-up visit if it was not important. I also understand that Sunshine Valley Pediatrics cannot call me and remind me that I need to make a follow-up appointment. Therefore, it is my responsibility to make the appointment and I accept all responsibility if I should fail to schedule or attend a follow-up visit.

• As the child's parent I understand that it is my responsibility to make and attend my appointments when referred to a specialist. I accept all responsibility if I fail to schedule or attend an appointment with a specialist.

PLEASE SIGN TO INDICATE YOU UNDERSTAND AND ACCEPT OUR POLICIES.

Responsible Party (Print) _____ Date _____

Responsible Party (Sign) _____