SUNSHINE VALLEY PEDIATRICS

SUMMERLIN LOCATION
7455 W. Washington Ave., #300
Las Vegas, Nevada 89128
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 REGISTRATION FORM

PREFERRED PEDIATRICIAN:

- ☐ WESLEY ROBERTSON, MD, JD, FAAP
- ☐ LAURA WEIDENFELD, MD, FAAP
- ☐ TRESA CHAKKALAKKAL, MD, FAAP
- ☐ HELEN YANG, MD, FAAP
- ☐ AMBER HULL, DO, FAAP
- ☐ JACK JU, MD

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	
DATE OF BIRTH	AGE	SEX M F	
ADDRESS	CITY	STATE	ZIP
PRIMARY PHONE #	SECONDARY PHONE #		

ETHNICITY

- ☐ AMERICAN INDIAN
- ☐ AFRICAN AMERICAN
- ☐ CAUCASIAN
- ☐ ASIAN
- ☐ PACIFIC ISLANDER
- ☐ HISPANIC/LATINO
- ☐ DECLINED
- ☐ OTHER

PARENT / LEGAL GUARDIAN INFORMATION

LAST NAME	FIRST NAME	M.I.	
ADDRESS (IF SAME AS PATIENT, WRITE SAME)	CITY	STATE	ZIP
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY #	
EMPLOYER	MARITAL STATUS		
CELL PHONE	HOME PHONE	WORK PHONE	
EMAIL ADDRESS	PLEASE CIRCLE THE BEST WAY TO CONTACT YOU		
	CELL	HOME	WORK

PARENT / LEGAL GUARDIAN INFORMATION

LAST NAME	FIRST NAME	M.I.	
ADDRESS (IF SAME AS PATIENT, WRITE SAME)	CITY	STATE	ZIP
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY #	
EMPLOYER	MARITAL STATUS		
CELL PHONE	HOME PHONE	WORK PHONE	
EMAIL ADDRESS	PLEASE CIRCLE THE BEST WAY TO CONTACT YOU		
	CELL	HOME	WORK

INSURANCE INFORMATION

PRIMARY INSURED'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY #
PRIMARY INSURANCE CARRIER	POLICY #		GROUP #
INSURANCE CLAIMS ADDRESS	CITY	STATE	ZIP

We do NOT bill secondary private insurances, ONLY government insurances (i.e. Medicaid, Tricare, CHAMPVA)

PLEASE COMPLETE BACK SIDE

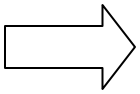
SIBLING INFORMATION (IF UNDER 21 YEARS OF AGE)		
SIBLING NAME #1	DATE OF BIRTH	AGE
SIBLING NAME #2	DATE OF BIRTH	AGE
SIBLING NAME #3	DATE OF BIRTH	AGE

EMERGENCY CONTACT INFORMATION (OTHER THAN PARENT/GUARDIAN)		
EMERGENCY CONTACT #1	PHONE	RELATIONSHIP TO PATIENT
EMERGENCY CONTACT #2	PHONE	RELATIONSHIP TO PATIENT

PHARMACY INFORMATION			
PHARMACY NAME	PHONE #		
ADDRESS	CITY	STATE	ZIP
PHARMACY'S CROSS STREETS			

POLICIES	
YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, REGARDLESS OF INSURANCE	
INITIAL	DESCRIPTION
	You agree to pay all insurance co-pays at the time of check-in & prior to services being rendered & all deductibles & co-insurance 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 & 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 Sunshine Valley Pediatrics, 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 & 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 & 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 Sunshine Valley Pediatrics 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 & 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 & remind me that I need to make a follow-up appointment. Therefore, it is my responsibility to make the appointment & 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 & attend my appointments when referred to a specialist. I accept all responsibility if I fail to schedule or attend an appointment with a specialist.
	You agree & understand that any damages to Sunshine Valley Pediatrics' facility, equipment or property by you, your child, or associated party will be your financial responsibility. Any damages or destruction incurred to Sunshine Valley Pediatrics will result in recuperation of reparation costs & could be subject to termination from the practice.

PLEASE SIGN TO INDICATE YOU UNDERSTAND & ACCEPT OUR POLICIES.



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RESPONSIBLE PARTY (SIGNATURE) RESPONSIBLE PARTY (PRINT) DATE