In order to bill your insurance company, we need to have this form fully completed for each patient annually. The front and back must be complete with signature and date. We appreciate your help and cooperation with this!

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

PREFERRED PEDIATRICIAN: (PLEASE CIRCLE ONE)

WESLEY ROBERTSON, MD, FAAP
HELEN YANG, MD, FAAP
LAURA WEIDENFELD, MD, FAAP
JACK JU, MD
TRESA CHAKKALAKKAL, MD, FAAP
ERIC SALES, MD, FAAP, CAQSM

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

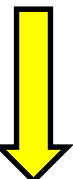
PARENT / LEGAL GUARDIAN INFORMATION

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

please complete back



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)

SIBLING INFORMATION (IF UNDER 21 YEARS OF AGE)

SIBLING NAME #1	DATE OF BIRTH	AGE	√ IF ADDRESS SAME AS PATIENT ☐
SIBLING NAME #2	DATE OF BIRTH	AGE	√ IF ADDRESS SAME AS PATIENT ☐
SIBLING NAME #3	DATE OF BIRTH	AGE	√ IF ADDRESS SAME AS PATIENT ☐

EMERGENCY CONTACT INFORMATION (OTHER THAN PARENT/GUARDIAN)

EMERGENCY CONTACT #1	PHONE	RELATIONSHIP TO PATIENT
EMERGENCY CONTACT #2	PHONE	RELATIONSHIP TO PATIENT

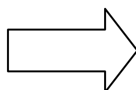
PHARMACY INFORMATION

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.
	You agree & understand that we may incur expenses as a result of non-payment for any medical services rendered to you or your dependents. Accordingly, in the event that your account becomes more than 120 days delinquent, you agree that we may add a fee of up to $50.00 to offset any fees we will have to incur to recover your outstanding balance. We may also charge interest at a rate of 1.5% monthly on your outstanding balance.
	If you miss an appointment without 24-hour prior notification, you agree to pay a $50.00 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 medical assistant 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.

RESPONSIBLE PARTY (SIGNATURE)	RESPONSIBLE PARTY (PRINT)	DATE