SONRISE Pediatrics & Wellness

305 Sunrise Center
PO Box 2852
Zanesville OH 43701
P: 740-562-6868
F: 740-205-8661

Patient and Family Information

Patient Name: _____ DOB: ____/____/____ Gender: M / F
Last First

Patient Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ County: _____

Name of parent/legal guardian #1	Name of parent/legal guardian #2
Custodial parent Yes No	Custodial parent Yes No
Birthdate:	Birthdate:
Address:	Address:
Cell Phone:	Cell Phone:
Email:	Email:
Employer:	Employer:
Occupation:	Occupation:
Alternate phone:	Alternate phone:
SS #	SS #

☐ I acknowledge that SonRise Pediatrics & Wellness will contact me for appointment reminders, lab results or other important information by text or phone.

May all contacts listed above have access to the patient's records? Yes / No
If parents are divorced, separated or unmarried, please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

_____

Who should receive billing statements? _____

Patient Insurance:

Primary Policy: Policy Holder Name _____
Policy Holder birth date: _____ Policy Holder Gender: _____
Policy Holder SS#: _____ Relationship to patient: _____
Insurance Carrier: _____ ID# _____ Group# _____
Policy effective date: _____

Secondary Policy: Policy Holder Name _____
Policy Holder birth date: _____ Policy Holder Gender: _____
Policy Holder SS#: _____ Relationship to patient: _____
Insurance Carrier: _____ ID# _____ Group# _____
Policy effective date: _____

Emergency Contacts, other than parents. Name & Relationship:

☐ I give permission for the following persons to accompany my child for medical treatment and to make medical decisions in my absence.

Name:_____Phone: _____Relationship: _____
Name:_____Phone: _____Relationship: _____

Preferred Pharmacy Name:_____ Location: _____

Form Completed by: _____ Relationship to Patient: _____
Signature: _____ Date: _____