Sunrise Pediatrics

SunrisePediatricsLasVegas.com

Maryland Office: (702) 254-KIDS (5437)

Rainbow Office: (702) 361-KIDS (5437)

Smoke Ranch Office: (702) 820-KIDS (5437)

GENERAL INFORMATION

Patient Name:_____
First Middle Last

Date of Birth: _____/_____/_____ Age: _____ Gender: M / F

Mother's Name: _____

Father's Name: _____

Primary Address: _____Apt #_____

City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other: _____

Email Address: _____

Preferred Language: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ DOB: ____/___/_____

Relationship to Patient: Self Mother Father Other: _____

Insurance Company: _____

Policy Number:_____ Group #:_____

Employer: _____

Sunrise Pediatrics
SunrisePediatricsLasVegas.com

Maryland Office: (702) 254-KIDS (5437)
Rainbow Office: (702) 361-KIDS (5437)
Smoke Ranch Office: (702) 820-KIDS (5437)

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ DOB: ____/___/_____

Relationship to Patient: Self Mother Father Other: _____

Insurance Company: _____

Policy Number:_____ Group #:_____

Employer: _____

EMERGENCY CONTACT

Name: _____ Phone #: _____

PHARMACY

Preferred Pharmacy: _____

Pharmacy phone #: _____

Pharmacy Address or Cross Streets: _____

Sunrise Pediatrics
SunrisePediatricsLasVegas.com

Maryland Office: (702) 254-KIDS (5437)
Rainbow Office: (702) 361-KIDS (5437)
Smoke Ranch Office: (702) 820-KIDS (5437)

_____ _____
Print Patient Representative Name Relationship to Patient

RECEIPT OF ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I was offered to read or take with me a copy of the Privacy Policy issued by Sunrise Pediatrics, on the date indicated below. I understand that I may ask for a copy at any time.

To respect your privacy please tell us how we may contact you:
Home/ Cell Phone:

- ❑ You may leave a message with the following person(s) if I am not available: _____
- ❑ You may leave DETAILED INFORMATION on my voicemail.
- ❑ You may leave your NAME and PHONE NUMBER ONLY on my voicemail and I will return your call.

Work Phone:

- ❑ You may call my work place.
- ❑ You may leave DETAILED INFORMATION on my work voicemail.
- ❑ You may leave your NAME and PHONE NUMBER ONLY on my work voicemail and I will return your call.
- ❑ You may NOT call my workplace.

Please list parents, family, friends, caretaker, etc. that we may communicate with in regards to your child's personal medical and financial information. This will include but is not limited to: test results, appointment dates and times, and billing information. Only the names that are listed below will be able to receive your information. Do not include your physicians on this list.

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____
4. _____ Phone: _____

Unless you notify us in writing stating otherwise the above person(s) will always be able to receive information about you.

_____ _____
Patient's Signature Date

Sunrise Pediatrics
SunrisePediatricsLasVegas.com

Maryland Office: (702) 254-KIDS (5437)
Rainbow Office: (702) 361-KIDS (5437)
Smoke Ranch Office: (702) 820-KIDS (5437)

REQUEST FOR TREATMENT AND INSURANCE VERIFICATION

This is to certify that I, _____authorize Sunrise Pediatrics to file claims to my insurance company(s) for services rendered to me by Dr. Sanjay Kandoth or any of his medical providers. I certify that the information I have reported with regard to my insurance company is correct and understand that I am responsible to notify Sunrise Pediatrics if my insurance company changes, benefits are terminated or if the coverage I have reported is incorrect. I understand and agree that it is my responsibility to understand the benefits of my insurance plan and that failing to do so may result in lesser payment or no payment at all from my insurance carrier(s). I understand and agree that I am ultimately responsible for payments in full for all services that I have received from Sunrise Pediatrics.

If a referral is required, I understand that it is MY responsibility to obtain all documentation required by any insurance carrier or reimbursing agent in order to determine payable benefits.

_____ Parent/Guardian Initials

PAYMENT AT TIME SERVICES ARE RENDERED

I understand that payment of the Estimated Bill will be made at the times services are rendered. I understand that my Estimated Bill will be provided prior to leaving the office and will detail my expected out-of-pocket charges based on Sunrise Pediatrics' contractual fee schedule with my insurer and the details of my particular insurance plan. The Estimated Bill will detail all deductible, copay, and coinsurance expected to be owed by me to Sunrise Pediatrics. It is anticipated that my Explanation of Benefits will detail these charges after submission of my claim. My estimated payment could potentially result in an under-payment or overpayment based on my insurance carrier's determination of the filed claim. If an under-payment occurs, I understand that I will be billed for the remainder owed. Sunrise Pediatrics will issue a prompt refund for any overpayment that is made by me.

_____ Parent/Guardian Initials

Sunrise Pediatrics
SunrisePediatricsLasVegas.com

Maryland Office: (702) 254-KIDS (5437)
Rainbow Office: (702) 361-KIDS (5437)
Smoke Ranch Office: (702) 820-KIDS (5437)

FINANCIAL POLICY

Sunrise Pediatrics, is dedicated to providing our patients with the best possible care. We ask your help by understanding and cooperation with our financial policy. We must emphasize that as physicians, our relationship is with you, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

INSURANCES: We participate with many insurance companies. Please check with office staff to see if we participate with your insurance plan. If we DO participate with your insurance company, all services performed in our office will be submitted, unless we have received prior notification of non-covered services. All co-pays, deductibles and coinsurance amounts are your responsibility and due at the time of service.

CO-PAYS AND OUTSTANDING BALANCES:
All copays are due at the time of service. All outstanding balances on accounts are due at the time of service.

DISABILITY AND OTHER INSURANCE FORM COMPLETION:
Our office will complete your disability or other insurance claim forms. The fee for each form is $15 and must be paid in advance prior to completion of your form. PLEASE ALLOW 7-10 Business days for completion of your disability forms.

CHECKS RETURNED FOR INSUFFICIENT FUNDS:
If we receive a returned check for insufficient funds, we will immediately reverse the payment on your account and will also charge a $25 fee to your account.

COLLECTION ACCOUNTS:
Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event a bill goes unpaid without contacting the billing department to discuss payment options, the account will be turned over to collections. If your account is sent to our collection agency, a collection charge of 30% of the amount due may be added to the balance of your account. In the event your account is turned over to an attorney you will be responsible for any and all attorney fees plus court costs.

Sunrise Pediatrics

SunrisePediatricsLasVegas.com

Maryland Office: (702) 254-KIDS (5437)

Rainbow Office: (702) 361-KIDS (5437)

Smoke Ranch Office: (702) 820-KIDS (5437)

SELF-PAY POLICY:

Payment is expected at the time of service. Prompt pay discounts may be available, please check with billing staff for details.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY SUNRISE PEDIATRICS, AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_____ _____

Signature of Patient/Guardian Date

Sunrise Pediatrics

SunrisePediatricsLasVegas.com

Maryland Office: (702) 254-KIDS (5437)

Rainbow Office: (702) 361-KIDS (5437)

Smoke Ranch Office: (702) 820-KIDS (5437)

PATIENT HISTORY

Main Reason (s) for visit? (Complaints & Symptoms) List as many as you can in order of importance .

1) _____ length of time :_____
2) _____ length of time :_____
3) _____ length of time :_____
4) _____ length of time :_____

Other Health Issues: _____

Does your child have a contagious disease at this time? YES/NO

TRAUMAS, ACCIDENTS, HOSPITALIZATIONS, SURGERIES Date What Happened? Outcome? Comments?

1) _____
2) _____
3) _____

ALLERGIES Is your child hypersensitive or allergic to (food, drugs, environment?)

1) _____ Reaction: _____
2) _____ Reaction: _____
3) _____ Reaction: _____

FAMILY HISTORY Please circle if there is any history of the following conditions in your family:

allergies
asthma
cancer
depression
diabetes
eczema
heart disease
high cholesterol
high blood pressure
kidney disease
mental illness
Seizures
Sibling demise
Other: _____

Social History: Who does the child live with: Mother Father Other: _____

How many siblings does your child have? #_____

Sunrise Pediatrics
SunrisePediatricsLasVegas.com
Maryland Office: (702) 254-KIDS (5437)
Rainbow Office: (702) 361-KIDS (5437)
Smoke Ranch Office: (702) 820-KIDS (5437)

2 YEARS OLD AND YOUNGER ONLY

PREGNANCY HISTORY Were there any difficulties during pregnancy? YES/NO
Please circle any difficulties experienced during pregnancy:
gestational diabetes thyroid condition emotional trauma nausea/vomiting
physical trauma high blood pressure toxemia bleeding threatened miscarriage
Other:_____
Was the birth process natural? YES/NO
Were there any complications? _____
Were there any interventions during the birth? (ie. forceps, medications, epidural, induction, c-section, etc..)

_____
Were there any problems after the birth? _____

HEALTH HISTORY Was your child breastfed? YES/NO How long? _____
Any vomiting of mother's milk? YES/NO
Was formula used? YES/NO How long? _____ Was it soy formula? _____ What foods were introduced first? _____ When? _____
Any reactions to foods introduces? Please describe: _____
When was cow's milk introduced? _____

ALL PATIENTS

Is there anything that you exclude from your child's diet? _____
Is your child a picky eater? If so, please explain: _____
Does your child have any particular food likes or dislikes? _____
How much does your child drink? _____ What do they drink? _____
When did your child achieve developmental milestones? please circle: early average late
How many hours of sleep does your child get per night? _____ Is it restful? _____
Does your child routinely receive medications to lower fever if there is a fever? YES/NO
How many times has your child received a course of Antibiotics? _____
Are there any behavioral issues that are a concern for you? _____
Any significant fears? Night terrors? Please explain: _____

Sunrise Pediatrics
SunrisePediatricsLasVegas.com
Maryland Office: (702) 254-KIDS (5437)
Rainbow Office: (702) 361-KIDS (5437)
Smoke Ranch Office: (702) 820-KIDS (5437)

MEDICATION/SUPPLEMENTS Please list any prescription medications, over the counter medications, vitamins or other supplements your child is taking.

1) _____
2)_____
3)_____
4)_____

PREVIOUS ILLNESSES Please circle if there is any history of the following conditions:

allergies asthma bedwetting bladder infections bronchitis cavities chicken pox chronic nasal congestion clotting defects colic constipation cradle cap ear infections approx.# ___ epilepsy excessive perspiration failure to thrive fecal incontinence frequent colds frequent strep throat gas/bloating thrush growing pains headaches heart murmur hepatitis insomnia jaundice joint problems mono motion sickness night terrors Parasites/worms pneumonia rashes stomach aches tonsillitis approx.# ___ Other:

_____

Has your child had any of the following tests? When? Where? Result?

Electroencephalogram (EEG) _____
Psychological evaluation _____
Hearing tests _____
Speech/Language tests _____

IMMUNIZATIONS: Have your child received vaccinations in any other state but Nevada? Yes/No. If so where: _____
Any adverse reactions to any vaccine? YES/ NO If yes, please describe:

_____

TYPICAL FOOD INTAKE

Breakfast:_____
Lunch: _____
Dinner: _____
Snacks: _____
To Drink: _____

Sunrise Pediatrics
SunrisePediatricsLasVegas.com
Maryland Office: (702) 254-KIDS (5437)
Rainbow Office: (702) 361-KIDS (5437)
Smoke Ranch Office: (702) 820-KIDS (5437)

REVIEW OF SYSTEMS: Please circle all that apply:
General: Fever, weight loss/gain, change in activity level
Neuro: headache, trauma, loss of consciousness, seizure activity, developmental delays
HEENT: Change in vision, hearing, runny nose, ear pain, sore throat, neck pain
CV: shortness of breath, sweating, color changes with feeding, chest pain, palpitations, recent history of murmur, fainting, or dizziness with activity
Respiratory: Cough, wheezing, shortness of breath
GI: Nausea, vomiting, diarrhea, constipation,
GU: frequency, urgency, blood in urine
Endo: excessive thirst, excessive urination, heat/cold intolerance, growth pattern
MS: joint pain, trauma, limpness, weakness
Skin: Rashes, bruising
Psych/behavior: clingy, fussy, decreased energy level, overactive