Sunnie Skiles, MD

PROYOUTH PEDIATRIC HEALTH & WELLNESS
Registration Form

6815 Five Star Blvd
Rocklin, CA 95677

Patient Information (Please Print)
Patient Name: _____ Date: _____
Sex: M F Age: _____ Date of Birth: _____
Mother/Legal Guardian Name: _____
SSN: _____ Date of Birth: _____
Driver's License#: _____ E-Mail: _____
Address: _____
City: _____ Zip Code: _____
Home Phone: _____ Mobile Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Father/Legal Guardian Name: _____
Address if different than above: _____
SSN: _____ Date of Birth: _____
Driver's License#: _____ E-Mail: _____
Home Phone: _____ Mobile Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Siblings Names/Dates of Birth/Sex: _____
_____
Emergency Contact Name (not living with you): _____
Relation to Patient: _____ Phone: _____ Alternate Phone: _____

Race: ☐ Decline to report ☐American Indian or Alaska Native ☐Native Hawaiian or other Pacific Islander ☐Black or African American ☐White ☐Hispanic ☐Other Race _____
Language: _____

INSURANCE INFORMATION
Primary Insurance Company: _____ Type of Insurance: ☐HMO ☐PPO ☐POS ☐Other
Primary Insured's Date of Birth: _____ Primary Insured's SSN: _____
Primary Insured's Name: _____ Relationship to Patient: _____
ID# _____ Group# _____ Effective Date: _____

ASSIGNMENT AND RELEASE
I the undersigned certify that I (or my dependent) have insurance coverage as above and assign directly to Pediatric Health & Wellness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature | Relationship to Patient | Date

PRIVACY POLICY
At Pediatric Health & Wellness we are committed to ensuring patient privacy and confidentiality. Please sign below to indicate that you and the responsible party have had an opportunity to read and understand our privacy policy.

_____ _____ _____
Responsible Party Signature | Relationship to Patient | Date

CONSENT TO CALL – AUTHORIZATION TO RECEIVE AUTOMATED PHONE CALLS – We use an automated telephone system for appointment reminders and other information from time to time. Please sign below to authorize us to contact you via our automated phone call system.

I consent to receive automated phone calls from Pediatric Health & Wellness:

_____ _____ _____
Responsible Party Signature | Relationship to Patient | Date

TO OPT OUT, SIGN HERE: I DO NOT WISH TO RECEIVE AUTOMATED PHONE CALLS: _____