Sunshine Healthcare Solutions

Primary Care Specializing in You

Susan G. Schneider, MD, MSPH

New Patient Registration Form

(Please Print)

PATIENT INFORMATION			
Patient's First Name:	Middle name:	Last name:	
Patient Date of Birth:	Patient Sex: ☐ M ☐ F	Social Security no.:	Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ other
Patient Email			
Home phone no.:	Work phone no.:	Cell phone no.:	
Mailing address:	City:	State:	ZIP code:
If patient is a senior with a legal Power of Attorney , please give POA/guardian/parent names and specify relation to patient:			

IN CASE OF EMERGENCY			
Name of emergency contact person:	Relationship to patient:	Home phone no.:	Work phone no.:
Mailing address:	City:	State:	ZIP code:
E-Mail address:			

465 Minutemen Cswy #455 ● Cocoa Beach, FL 32931 ● Phone (866) 389-7601
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Employer Information:			
Occupation:		Employer Name:	
Business Mailing address:	City:	State:	ZIP code:

Statistical:	
Language: ☐ English ☐ Spanish ☐ French ☐ German ☐ other ______________________________	Race: ☐ Caucasian ☐ Hispanic ☐ Pacific Islander ☐ Black ☐ Asian ☐ Native American ☐ other
Current Living Situation: ☐ Independent ☐ Assisted Living Facility ☐ Skilled Nursing Facility ☐ Live with Family	Do You need an Interpreter? ☐Yes ☐No
Accouterments? (Check all that apply) ☐ Vision Impairment ☐ Hearing Impairment ☐ Impeded Mobility ☐ Immobile ☐ Difficulty Writing ☐ Cognitive Impairment ☐ Wheelchair ☐ Any Other ____________________________________	

OTHER INFORMATION			
Pharmacy name:	Pharmacy location:		Pharmacy phone no:
May we notify you of appt. / test results at your E-Mail address? Or Alternate Email:		☐Yes ☐No	
May we leave messages of test results on your answering machine?	☐Yes ☐No	May we notify you of appointments at this mailing address?	☐Yes ☐No
May we leave voicemail messages of appointments on your answering machine?	☐Yes ☐No	May we notify you of test results at this mailing address?	☐Yes ☐No

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INSURANCE INFORMATION			
Name of primary insurance:	Policy subscriber's name, if not patient:		Policy subscriber's date of birth:
Policy Number:		Policy Effective Date:	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:			
Name of secondary insurance (if applicable):	Policy subscriber's name, if not patient:		Policy subscriber's date of birth:
Policy Number:		Policy Effective Date:	
Patient's relationship to subscriber: Self Spouse Child Other, please specify:			

RESPONSIBLE PARTY (GUARANTOR)			
The guarantor is the person responsible for the patient's bill. If the patient is responsible for his / her own bill, please skip the next section. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.			
Guarantor's last name:	Guarantor's first name:	Guarantor's middle name:	
Guarantor's mailing address, if different from patient:	City:	State:	ZIP code:
Guarantor's phone number:	Relationship to patient:	Guarantor's date of birth:	Guarantor's Social Security No.:

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