

# Attending Physician's Statement (Child Delivery)



Please PRINT clearly.  
Use BLACK ink.  
If with erasures, please countersign.

In this form, "you" and "your" refer to the policy owner, life insured, patient and the physician whose information we are processing or disclosing. *We, us, our* and *the Company* refer to Sun Life of Canada (Philippines), Inc., a member of the Sun Life Financial group of companies.

The patient is responsible for the completion of this form without expense to Sun Life of Canada (Philippines), Inc.

## 1 General Information (to be completed by the patient)

### I. Relating to the Patient

Name (Last Name, First Name, M.I.)	Date of Birth (month/day/year)
Residence Address (number, street, municipality)	
Contact Number/s	E-mail Address
Policyowner (last name, first name, M.I.) - Please complete if policyowner is other than the life insured	

<b>Authorization</b> By signing below, you allow us to process and disclose your personal and sensitive personal information to third parties so that we can better help you meet your lifetime needs.  If you need more information about our privacy policy, please visit <a href="https://apps.sunlife.com.ph/privacy">https://apps.sunlife.com.ph/privacy</a> .	Signature of Patient	Printed Name of Patient
		Date of Signing (month/day/year)

## 2 Physician or Surgeon's Statement

1.a. Date of delivery. (month/day/year)	1.b. Are you the regular OB-Gynecologist of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, give name of doctor who referred the patient to you.
2. Give the <u>names</u> and <u>addresses</u> of other attending doctors of the patient.	
<u>Names</u>	<u>Addresses</u>
3. Type of delivery (pls. check appropriate box)	
<input type="checkbox"/> Normal delivery	<input type="checkbox"/> Caesarian Section delivery
4. This is the patient's ___ delivery. (pls. check appropriate box)	
<input type="checkbox"/> first	<input type="checkbox"/> second
<input type="checkbox"/> third	<input type="checkbox"/> others, specify
5. Were there any complications during delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give details.	



## 2 Physician or Surgeon's Statement - continued

6. On what date were you first consulted by the patient? (month/day/year)	7. Reason for consultation		
8. Was the patient referred to you by another doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No      If "Yes", please provide name and address of referring doctor			
9. What health history was disclosed when the patient first consulted you?			
10. Please provide details of the patient's habits in relation to smoking. Does the patient smoke cigarettes/cigarillos/cigars or consume any other tobacco product? <input type="checkbox"/> Yes <input type="checkbox"/> No			
a. If "Yes", fill out appropriate box with quantity per day.			
cigarettes	E-cigarettes	cigars	others
b. If "No", has the patient ever smoked a cigarette/cigarillo/cigar or consumed any other tobacco product in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes", when was the last time the patient smoked a cigarette/cigarillo/cigar or consumed any other tobacco product? <input style="width: 100%;" type="text" value="month/year"/>	

## 3 Signature

Signature of Attending Physician <b>X</b>	Printed Name of Attending Physician	
Place of Signing	Date of Signing (month/day/year)	
Field of Specialization	License No.	PTR No.
Contact Number/s	E-mail Address	
Medical Office Address		