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	

Authorization
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 https://apps.sunlife.com.ph/privacy.

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? ☐ Yes ☐ No
If No, give name of doctor who referred the patient to you.

2. Give the names and addresses of other attending doctors of the patient.

Names	Addresses

3. Type of delivery (pls. check appropriate box)

☐ Normal delivery ☐ Caesarian Section delivery

4. This is the patient's ___ delivery. (pls. check appropriate box)

☐ first ☐ second ☐ third ☐ others, specify

5. Were there any complications during delivery? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No

If *"Yes"*, when was the last time the patient smoked a cigarette/cigarillo/cigar or consumed any other tobacco product?

month/year

3 Signature

Signature of Attending Physician X		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		