PEDIATRIC ASSOCIATES OF WHIDBEY ISLAND

Patient Registration

PATIENT INFORMATION:

Birth Name (First)_________________________________(M.I.) ____(Last)____________________________________

Preferred Name________________________________Pronouns____

Address_______________________________________City__________________________State ____ Zip___________

Date of Birth_________________________Age________Birth Sex ___Male____Female Gender Identity___________

PATIENT cell phone____________________________ May we leave a message?_____yes ____No

Preferred Language English___ Other______________________

Ethnicity (circle) Unknown / Hispanic or Latino / Non-Hispanic or Latino / Decline to answer

Race (circle) American Indian / Asian / Black or African American / Hawaiian or Pacific Islander /White / Decline

1.Parent/Guardian Info ___Mother ___Father ___Other Biological Parent? Yes/No ___Guardian ___Step Parent

Name ____Date of Birth ___________________________

Address (if different) ____City/State/Zip ___________________________

Social Security Number____ Policy Holder on Insurance? ___Yes ___No

Primary Contact Phone ____ Email_________________________________

Where do you want appt reminders sent? Text to cell _________________________Call Home __________________

Are we permitted to leave detailed messages on your contact phone numbers? ___Yes ___No

Employer ____ Occupation _____________________________

2.Parent/Guardian Info ___Mother ___Father ___Other Biological Parent? Yes/No ___Guardian ___Step Parent

Name ____Date of Birth ___________________________

Address (if different) ____City/State/Zip ___________________________

Social Security Number____ Policy Holder on Insurance? ___Yes ___No

Secondary Contact Phone _____________________________________Email__________________________________

Where do you want appt reminders sent? Text to cell _________________________Call Home __________________

Are we permitted to leave detailed messages on your contact phone numbers? ___Yes ___No

Employer ____ Occupation _____________________________

EMERGENCY CONTACT (Other than Parent)

Name____Phone ______________________Relation____________

ASSIGNMENT OF BENEFITS / CONSENT TO EXAM AND TREATMENT

I authorize payment of medical benefits to the Providers of PAWI. I also authorize the release of medical record information necessary to process the insurance claim. I understand that regardless of insurance coverage, I am responsible for my account and any balances due. I further give consent to have my child evaluated and treated by PAWI and its associates. The above information is accurate and complete to the best of my knowledge.

PRIVACY PRACTICES: *I acknowledge that Pediatric Associates of Whidbey Island's "Notice of Privacy Practices" has been offered to me. The notice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any revised Notice will be provided to me or made available to me.*

Signature____

Relationship to Patient ____ Date___________________________________

Flip Over for Additional Authorization!

Additional Authorization

I also, **give permission to the following to seek medical treatment for my child(ren) in my absence.**
Please list first and last name of person being named.

(___) Step-parent: ____
(___) Grandparent(s):____
(___) Family Friend: ____
(___) Other: ____
(Relationship to patient)

*******_____ Initial here if you also give permission for above-named person(s) to speak with any representative (i.e. nurse, physician, receptionist, etc.) of *Pediatric Associates of Whidbey Island* regarding above-named minor patient(s).

______________________	______________________	______________________
Signature	**Relationship to patient**	**Date**

You may revoke or amend this permission at any time by notifying *Pediatric Associates of Whidbey Island* in writing.

Pediatric Associates of Whidbey Island

Flip Over for Additional Authorization!