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 _____

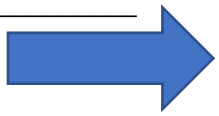
2.Parent/Guardian Info ___Mother ___Father ___Other Biological Parent? Yes/No ___Guardian ___Step Parent
Name _____Date of Birth _____
Address (if different) _____City/State/Zip _____
Social Security Number_____ Policy Holder on Insurance? ___Yes ___No
Secondary Contact Phone _____Email_____
Where do 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 _____

INSURANCE INFORMATION
Name of Insurance _____Policy#_____Group#_____
Subscriber Name _____ Date of Birth _____ SSN _____
Are you covered by Medicaid(Apple Plan) ?
Circle one: Amerigroup / CHPW / Coordinated Care / Molina

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. Parent/Guardian Signature _____Date _____



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 _____

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