Pediatric Associates of Whidbey Island
Registration Form

Please list ONLY those children who are under the age of 18 and for whom you are the legal guardian and who share the same parents. Request a separate form for additional children.

Child's Legal Name_____**Birthdate**_____ **Sex:** ☐ **M** ☐ **F** ☐ **NB**

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PREFERRED METHOD OF CONTACT: CHOOSE ONE:

Via TEXT Specify #_____ **OR Via Phone Specify number:**_____

I authorize P*ediatric Associates of Whidbey Island* to deliver the following types of messages by voice call or text messaging using an automatic telephone dialing system or an artificial or pre-recorded voice to include by not limited to; appointment reminders, visit recall and seasonal services. (Flu Clinic)

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Parent/Guardian #1_____ **Relationship to Patient**_____

Parent's Birthdate _____ **Social Security #** _____ **Employer** _____

Parent's Mailing Address _____

Lives with patient? Yes ☐ **No** ☐ **Parent's Email** _____

Priority Phone # _____ ☐ **Home** ☐ **Cell** ☐ **Work**

Secondary Phone #_____ ☐ **Home** ☐ **Cell** ☐ **Work**

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Parent/Guardian #2_____**Relationship to Patient** _____

Parent's Birthdate _____ **Social Security #** _____ **Employer** _____

Parent's Mailing Address _____

Lives with patient? Yes ☐ **No** ☐ **Parent's Email** _____

Priority Phone # _____ ☐ **Home** ☐ **Cell** ☐ **Work**

Secondary Phone #_____ ☐ **Home** ☐ **Cell** ☐ **Work**

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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** _____

*****PLEASE CONTINUE TO REVERSE SIDE FOR MORE INFORMATION*****

FINANCIAL RESPONSIBILITY

I hereby authorize *Pediatric Associates of Whidbey Island* to release any medical or other information necessary in order to process insurance claims/billing on my behalf. I authorize payment directly to the doctor for any benefits available under my insurance plan. I hereby assign to the physician all payments for medical services rendered. I understand that I am financially responsible for any amount not covered by my insurance. I understand that I am responsible for all fees, regardless of insurance coverage. Co-payments must be paid at the time of service.

Signature of Parent/Guardian (if patient is under age 18) _____Date _____

Authorization for treatment of a minor

I, _____,the parent/legal guardian, hereby authorize the Providers of PAWI to provide medical care to my child(ren).

_____	_____	_____
Signature	**Relationship to patient**	**Date**

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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
275 SE Cabot Drive, Suite B-102
Oak Harbor, WA 98277
