Pediatric Associates of Whidbey Island
Registration Form

Please list ONLY those children for whom you are the legal guardian and who share the same parents. Request a separate form for additional children. If you have questions, please ask the receptionist for clarification.

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

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Preferred Method of Contact: CHOOSE ONE:

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

OR Via Portal? Specify email address: _____

I authorize Pediatric Associates of Whidbey Island to deliver our cause to be delivered 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)

PATIENT PORTAL: Please ask the receptionist to enroll you in our secure portal for limited access to your child's medical record.

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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**

****

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:

INSURANCE INFORMATION: **Must be presented at EVERY visit.

I hereby authorized *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 _____

Permission for Medical Treatment of a Minor

I, _____, _____,
(Guardian Name) (Relationship to patients)

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 of Parent Guardian **Date**

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

Pediatric Associates of Whidbey Island
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(360) 675-5555

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