WEST SIDE PEDIATRICS

Adult Patient Registration Info (must sign Financial/Office Policies form):

Last name_____ **First name** _____ **Middle initial** _____

DOB: ____ / _____ / _____ **SS#** _____/____/_____ **Email**_____

Mobile: _____ **Landline:** _____ **Work phone**: _____

I authorize messages that include protected health information to be left on ☐ Mobile ☐ Landline ☐ DO NOT LEAVE MESSAGES

I authorize automated reminder calls to be left on ☐ Mobile ☐ Landline ☐ DO NOT LEAVE AUTOMATED REMINDER CALLS

Signature: _____ **Today's Date:** ____ / _____ / _____

Address: (where adult patient resides)

Street: _____City_____State _____ Zip _____

Financially Responsible Contact (must sign Financial/Office Policies form):

☐ ***Same as Adult Patient listed above*** (you do not need to fill in anything else below if you are the financially responsible party)

☐ ***Other (If other, please complete below:)***

Last name_____ **First name** _____ **Middle initial** _____

Relationship to adult patient: _____

DOB: ____/ ____/ _____ **SS#** ____/____/ _____ **Email**_____

Mobile: _____ **Landline:** _____ **Work phone**: _____

I authorize messages that include protected health information to be left on ☐ Mobile ☐ Landline ☐ DO NOT LEAVE MESSAGES

I authorize automated reminder calls to be left on ☐ Mobile ☐ Landline ☐ DO NOT LEAVE AUTOMATED REMINDER CALLS

Signature: _____ **Today's Date:** ____ / _____ / _____

Street: _____City_____State _____ Zip _____

*Authorization will expire if: a) the patient listed above receives a new legal financially responsible contact, b) the patient listed above ages out of the practice, c) the patient listed above is no longer a patient of West Side Pediatrics. The patient or their financially responsible contact may revoke this authorization in writing at any time. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you or the above named patient.