WEST SIDE PEDIATRICS

**-PRIMARY CONTACT-Legal Parent/Guardian#1:**

**Last name**_________________________________________ **First name**_________________________________________**Middle initial** _____

**Relationship to the patient:** ☐ Mother ☐ Father ☐ Other _________________________________________________

**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 child resides):**

**Street:** _________________________________**City**_______________________**State** ______ **Zip** __________

**PLEASE LIST ALL PATIENTS (under 18 yrs of age) WHO ARE THE LEGAL CHILDREN OF PARENT/GUARDIAN#1:**

**-PATIENT A Name** ______________________________________________ **DOB**: ___ /___ /___ **Legal Sex:** ☐**male** ☐**female** **SS#** ___ /___ /______

**Relationship to you**:_________________________________________________

**SECONDARY CONTACT-Legal Parent/Guardian#2 Name** ______________________________________________________________________

**Relationship to the patient:** ☐ Mother ☐ Father ☐ Other _________________________________________________ **DOB:** ____ / _____ / _________

**Mobile**: _______________________ **Street:** __________________________________________**City**____________________**State** ______ **Zip** __________

**Financially Responsible Contact for PATIENT A (must sign Financial & Office Policies Form)**:

☐ ***Same as Legal Parent/Guardian #1*** ☐ ***Same as Legal Parent/Guardian #2*** ☐ ***Other** (**If other, please complete below**:)*

**Last name**_____________________________________ **First name** ________________________________**Middle initial** ______

**Relationship to patient:** _____________________________________ **DOB**: ____/ ____/ ____ **SS#** ____/ ____/ ____

**Email**________________________________________________ **Mobile:** __________________________________

**Street:** _________________________________**City**_______________________**State** ______ **Zip** __________

**-PATIENT B Name** ______________________________________________ **DOB**: ___ /___ /___ **Legal Sex:** ☐**male** ☐**female** **SS#** ___ /___ /______

**Relationship to you**:_________________________________________________

☐ **Same SECONDARY CONTACT-Legal Parent/Guardian#2**

☐**Other Legal Parent/Guardian#2 Last name**___________________________ **First name** _______________________**Middle initial** ______

**Relationship to the patient:** ☐ Mother ☐ Father ☐ Other _________________________________________________

**DOB:** ____ / _____ / _____ **Mobile**: _________________ **Street:** _________________________**City**____________________**State** ______ **Zip** __________

**Financially Responsible Contact for PATIENT B (must sign Financial & Office Policies Form)**:

☐ ***Same as Legal Parent/Guardian #1*** ☐ ***Same as Legal Parent/Guardian #2*** ☐ ***Other** (**If other, please complete below**:)*

**Last name**_____________________________________ **First name** ________________________________**Middle initial** ______

**Relationship to patient:** _____________________________________ **DOB**: ____/ ____/ ____ **SS#** ____/ ____/ ____

**Email**________________________________________________ **Mobile:** __________________________________

**Street:** _________________________________**City**_______________________**State** ______ **Zip** __________

**-PATIENT C Name** _______________________________________________ **DOB**: ___ /___ /___ **Legal Sex:** ☐**male** ☐**female** **SS#** ___ /___ /______

**Relationship to you**:_________________________________________________

☐ **Same SECONDARY CONTACT-Legal Parent/Guardian#2**

☐**Other Legal Parent/Guardian#2 Last name**___________________________ **First name** _______________________**Middle initial** ______

**Relationship to the patient:** ☐ Mother ☐ Father ☐ Other _________________________________________________

**DOB:** ____ / _____ / _____ **Mobile**: __________________ **Street:** _________________________**City**____________________**State** ______ **Zip** _________

**Financially Responsible Contact for PATIENT C (must sign Financial & Office Policies Form)**:

☐ ***Same as Legal Parent/Guardian #1*** ☐ ***Same as Legal Parent/Guardian #2*** ☐ ***Other** (**If other, please complete below**:)*

**Last name**____________________________________ **First name** _______________________________**Middle initial** ______

**Relationship to patient:** ____________________________________

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

**Mobile:** ___________________ **Landline**: ______________________ **Work phone:** _____________________

**Street:** ________________________________**City**_______________________**State** ______ **Zip** _________

**-PATIENT D Name** _______________________________________________ **DOB**: ___ /___ /___ **Legal Sex:** ☐**male** ☐**female** **SS#** ___ /___ /______

**Relationship to you**:_________________________________________________

☐ **Same SECONDARY CONTACT-Legal Parent/Guardian#2**

☐**Other Legal Parent/Guardian#2 Last name**___________________________ **First name** _______________________**Middle initial** ______

**Relationship to the patient:** ☐ Mother ☐ Father ☐ Other _________________________________________________

**DOB:** ____ / _____ / _____ **Mobile**: __________________ **Street:** _________________________**City**____________________**State** ______ **Zip** _________

**Financially Responsible Contact for PATIENT D (must sign Financial & Office Policies Form)**:

☐ ***Same as Legal Parent/Guardian #1*** ☐ ***Same as Legal Parent/Guardian #2*** ☐ ***Other** (**If other, please complete below**:)*

**Last name**____________________________________ **First name** _______________________________**Middle initial** ______

**Relationship to patient:** ____________________________________

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

**Mobile:** ___________________ **Landline**: ______________________ **Work phone:** _____________________

**Street:** ________________________________**City**_______________________**State** ______ **Zip** _________

*Authorization will expire if: a) any minor listed above receives a new legal parent/guardian, b) any minor listed above turns 18 years of age, c) any patient listed above ages out of the practice, d) any patient listed above is no longer a patient of West Side Pediatrics. The listed legal parent/guardian 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/your child.