

-PRIMARY CONTACT-Legal Parent/Guardian#1: First name Middle initial Last name 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 \square Mobile \square Landline \square DO NOT LEAVE MESSAGES Lauthorize automated reminder calls to be left on Mobile Landline DO NOT LEAVE AUTOMATED REMINDER CALLS Today's Date: / / Address (where child resides): 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: Language SS# / / Relationship to you:_____ SECONDARY CONTACT-Legal Parent/Guardian#2 Name Relationship to the patient: Mother Other Other Other DOB: ___/ _____ 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 ____ DOB: / / SS# / / Relationship to patient: Mobile: _____City______State _____ Zip Street: -PATIENT B Name DOB: / / Legal Sex: Imale Ifemale 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:) First name ____Middle initial _____ Last name Relationship to patient: _____ DOB: ___/ ___ SS# ___/ ___/ Mobile: Email State Zip City____ Street:

-PATIENT C Name		DOB:/ Lega	al Sex:
Relationship to you:			
☐ Same SECONDARY CONTACT-Legal P	arent/Guardian#2		
Other Legal Parent/Guardian#2 Last name_		First name	Middle initial
Relationship to the patient: Mother Fa	ather Other		
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^{*}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.