Pediatric Physicians, PC

18+ Registration

Your full name: _____ Male:_____ Female:_____

Date of Birth: ____/____/_____ Preferred Name:_____

Address: _____

City: _____State:_____ Zip Code: _____

Home phone #:_____ Mobile phone #:_____

Do you live with your parents?_____ If not, who?_____ Relationship _____

Father's full name: _____DOB:____/_____/_____ Phone #_____

Mother's full name:_____DOB: ____/_____/_____ Phone # _____

Emergency contact: _____Phone #: _____ Relationship: _____

Access to my Protected Health Information (PHI):

As a patient 18 years or older, I have been made aware of my rights to privacy and I authorize the following to have access to my medical information:

_____
(Name must be written out completely. Writing “mom” or “dad” is not sufficient.)

_____
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_____ _____
Patient Signature Date