Kiwi Pediatrics Medical Group, Inc. **Registration and Authorization** **Date:** _____

Contact Information *(please write neatly so we get your information correctly)*

Primary Responsible Person

Last Name: _____ First Name: _____ Date of Birth: _____
Address: _____ Apt. _____
City: _____ Zip: _____ e-mail: _____
Phone (Cell): _____ Relation to patient: _____

Secondary Responsible Person

Last Name: _____ First Name: _____ Date of Birth: _____
Address: _____ Apt. _____
City: _____ Zip: _____ e-mail: _____
Phone (Cell): _____ Relation to patient: _____

Emergency Contact (not one of the above responsible persons)

Name: _____ Phone: ( ) _____ Relationship: _____

Patient Information: *(Please include phone and e-mail for patients age 12 and older)*

Child #1 Name: _____ Birthdate: _____ Sex: _____
Child #2 Name: _____ Birthdate: _____ Sex: _____
Child #3 Name: _____ Birthdate: _____ Sex: _____

Child #1 Contact Info: Phone: _____ E-mail: _____

Child #2 Contact Info: Phone: _____ E-mail: _____

Child #3 Contact Info: Phone: _____ E-mail: _____

Authorization to Treat

I authorize the doctors, nurse practitioners and medical assistants of Kiwi Pediatrics to provide medical treatment to my children. The following listed people have my permission to bring my children in for medical care:

_____

I will not send my children in with another unlisted adult unless I provide additional written authorization.

Teens: By law, youth 12 and over can be seen without a parent or guardian for "sensitive services".
For other services, I permit my 14-18 year old teenage children to be treated without an adult present. **Initial** ____

Pharmacy information: I agree that Kiwi may receive pharmacy information showing what prescription medications have been prescribed by other prescribers. **Initial** ____

California Immunization Registry: I agree that Kiwi may share immunization data with the California Registry. This will allow other medical providers and schools to see immunization records when appropriate. **Initial** _____
The registry requests your childrens' race and ethnicity: _____ Initial to decline: _____

I have reviewed the Kiwi Notice of Privacy Practices and Office Policies**.** **Initial** _____

I agree to communication via text or email as outlined in Kiwi Notice of Privacy Practices: **Initial**: _____

Financial Responsibility

I agree to provide current insurance information and pay charges (including fees for No-Show and Late Cancellation) not covered by my children's insurance.

Signature: _____ Relationship: _____ Date: _____

Preferred Pharmacy _____ 3/2023