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

Contact Information *(please type in Adobe Acrobat so we get your information correctly)*

Primary Responsible Person

Last Name: ________________ First Name: _________________ Relation to Patient: ______________
Social Security Number: ___________________ Sex: _____ Date of Birth: ____________
Address: _________________________________ Apt. _____
City: _______________________ Zip: _________ e-mail: ____________________________
Phone-Cell: (____) __________________ Backup: (____) __________________

Secondary Responsible Person

Last Name: ________________ First Name: _________________ Relation to Patient: ______________
Social Security Number: ___________________ Sex: _____ Date of Birth: _______________
Address: _________________________________ Apt. _____
City: _______________________ Zip: _________ e-mail: ____________________________
Phone-Cell: (____) ______________ Backup: (____) ________________

Emergency Contact (not one of the above responsible persons)
Name: ______________________ Phone: (____) ___________________ Relationship: __________________

Patient Information: *(Please include phone and e-mail for patients age 13 and older)*

Child #1 Name: ______________________________ Date of Birth: _______________ Sex: _______
Child #2 Name: ______________________________ Date of Birth: _______________ Sex: _______
Child #3 Name: ______________________________ Date of Birth: _______________ Sex: _______

Patient's Contact Info: Name: _________Phone: ___________ E-mail: ___________________________

Patient's Contact Info: Name: _________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** ____

I have reviewed the Kiwi Privacy Policies and Office Policies**.** **Initial** ____

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

Signature: ______________________________ Relationship: _________________ Date: __________

Preferred Pharmacy ____
What made you choose Kiwi? ____

Thank You!