Kiwi Pediatrics Medical Group, Inc.

Registration and Authorization (adult) **Date: _____**

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

Patient

Last Name: _____ First Name: _____
Social Security Number: _____ Sex: _____ Date of Birth: _____
Address: _____ Apt. _____
City: _____ Zip: _____ e-mail: _____
Phone-Cell: (_____) _____ Backup: (_____) _____

Secondary Responsible Person (Insurance subscriber if the patient is not subscriber)

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 (please provide a contact likely to be available)

Name: _____Phone: (____) _____Relationship:_____

Authorization to Treat
I authorize the doctors, nurse practitioners and staff of Kiwi Pediatrics to provide me with medical treatment.

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 insurance.

Signature: _____ Date: _____

Preferred Pharmacy

_____

Thank you!