

**Contact Information** (please write neatly 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?** (circle all that apply) OB/Midwife/MD, Yelp, Friend, Berkeley Parent Network, Location, Insurance Co., Kiwi Website **Thank you!**