

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### **3516 12th Ave NE \* Olympia, WA 98506 \* 360-456-1600**

**PATIENTS INFORMATION**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ ☐ M ☐ F

First Name MI Last name Date of birth

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Street/PO Box City State Zip Code

Primary Contact number: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Home [ ]  Mobile [ ]  Other

**Other Children (seen as patients):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ ☐ M ☐ F

First Name MI Last name Date of birth

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First Name MI Last name Date of birth

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First Name MI Last name Date of birth

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First Name MI Last name Date of birth

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First Name MI Last name Date of birth

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**Parent or Guardian information:**  SSN:☐☐☐-☐☐-☐☐☐[ ]

*(Living in same household as patient*)

Relationship to patient: ☐Mother ☐Father ☐Grandparent [ ] Sibling ☐Foster Parent ☐Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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First Name MI Last Name Date of Birth

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Street/PO Box City State Zip Code

Primary Contact number: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Home [ ]  Mobile [ ]  Other

Other Contact number: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Home [ ]  Mobile [ ]  Other

**IS THE ABOVE ADDRESS THE CORRECT ONE FOR STATEMENT BILLING?**  ☐YES ☐NO[ ]

**Parent or Guardian information:**  SSN:☐☐☐-☐☐-☐☐☐[ ]

*(Other Contact*)

Relationship to patient: ☐Mother ☐Father ☐Grandparent [ ] Sibling ☐Foster Parent ☐Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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First Name MI Last Name Date of Birth

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Street/PO Box City State Zip Code

Primary Contact number: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Home [ ]  Mobile [ ]  Other

**IS THE ABOVE ADDRESS THE CORRECT ONE FOR STATEMENT BILLING?**  ☐YES ☐NO[ ]

**IS THE ABOVE ADDRESS THE CORRECT ONE FOR STATEMENT BILLING?**  ☐YES ☐NO[ ]

**Financial responsibility, Release of Information and Assignment of Benefits:**

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicates on the claim. I understand I am financially responsible for any balance not covered by my insurance company. A copy of this signature if just as valid as the original.

Signature Date Relationship to patient

**INSURANCE INFORMATION:**

**Primary Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Name of Plan Subscriber ID# Group# Effective date

Subscribers name Date of Birth Employer

Relationship to patient: ☐Mother ☐Father ☐Self ☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Name of Plan Subscriber ID# Group# Effective date

Subscribers name Date of Birth Employer

Relationship to patient: ☐Mother ☐Father ☐Self ☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for treatment of a minor:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent/legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the physicians of South Sound Pediatrics to provide medical care to the above name minor child.

Signature Date Relationship to patient

**Emergency Contact Information:** (*Relative/friend outside of the household)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name Last name Contact number Relationship to patient

\*\*Contact information will remain in place until changed in writing by you\*\*



Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Notice of Privacy Practices**

South Sound Pediatrics has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact Cindy Strandberg at (360) 456-1600 ext. 104 to obtain a current copy of the Notice of Privacy Practices of to ask questions.

**By my signature below I acknowledge receipt of the Notice of Privacy Practice given to me by a representative of South Sound Pediatrics.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature Printed name Relationship to patient Date

 **Notice of No-Show Policy**

South Sound Pediatrics has a responsibility to inform you of our no-show policy and consequences of no-show appointments.

We may change the No-Show Policy at any time, and you may contact Cindy Strandberg at (360) 456-1600 ext. 104 to obtain a current copy or to ask questions.

**By my signature below I acknowledge receipt of the No-Show Policy given to me by a representative of South Sound Pediatrics.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature Printed name Relationship to patient Date

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**Parental Advance Consent to Treat Minors**

**Authorization for South Sound Pediatrics:**

I hereby authorize and consent to routine and emergency medical treatment for my child by qualified medical personnel at South Sound Pediatrics. I authorize and consent to emergency medical treatment when deemed necessary or advisable to safeguard my child’s immediate health, and I cannot be reached within a reasonable time by reason of absence for the community or otherwise. I waive my right to informed consent to such treatment with the understanding what every attempt to contact me has been made.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature Printed name Relationship to patient Date

**Other Authorization:**

This is to certify that the person(s) **(not parents)** listed below has my permission to authorize necessary medical care for my child, if I am unable to accompany my child to their doctor’s appointment. This authorization will be in effect until revoked in writing by me. I accept financial responsibility for necessary treatment and services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name Relationship to patient Phone number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name Relationship to patient Phone number

Does the above-named person(s) have permission to speak with South Sound Pediatrics over the phone regarding your child’s health care information? ☐YES ☐NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature Printed name Relationship to patient Date

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**Health Questionnaire**

Please complete the following questions. Skip any that you can’t answer or do not apply to your child.

**Past Medical History (check all that apply)**

Is your child on any medications? [ ] Yes [ ] No

If yes, please list medications:

|  |  |  |  |
| --- | --- | --- | --- |
| NAME | DOSAGE | NAME | DOSAGE |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Any allergies to medications or foods? [ ] Yes [ ] No

If yes please list allergies including reaction type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any chronic medical problems (asthma, allergies, diabetes, seizures etc.)? [ ] Yes [ ] No

If yes please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been hospitalized? [ ] Yes [ ] No

If yes please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any past injuries or broken bones? [ ] Yes [ ] No

If yes please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Health questionnaire cont.**

Is your child up to date on immunizations? [ ] Yes [ ] No

Any previous reactions to immunizations? [ ] Yes [ ] No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social history**

Is your child in daycare? [ ] Yes [ ] No

Does anyone in your home smoke? [ ] Yes [ ] No

Are you interested in smoking cessation information? [ ] Yes [ ] No

Do you have pets at the home? [ ] Yes [ ] No

If so what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives at home with your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family history**

Does anyone in the immediate family (parents, siblings, maternal grandparents, paternal grandparents) have any of the following medical issues: (please circle)

ADHD Anemia Anxiety High blood pressure

Cancer Autism Developmental Delay Depression

Kidney Disease Liver Disease Diabetes Allergies

Asthma Hay fever Seizure Learning Disability

Substance abuse Heart Disease at early age? (Under age 55)

If you circled yes to any of the above, please list the family member’s relationship to your child: (example: hay fever – maternal grandmother)

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MY KIDS CHART SIGN UP AND AUTHORIZATION FORM

South Sound Pediatrics is pleased to announce our new patient portal: My Kids Chart. This portal will provide you to access your child’s chart wherever and whenever you need it.

With My Kids Chart you will be able to login and:

**\*Securely message your child’s nurse \*View past and present appointments**

**\*Access your child’s immunization record \*View your child’s current prescriptions**

**\*View your child’s lab results \*Access your child’s visit summary**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_authorize South Sound Pediatrics to communicate via my email address that I have provided for the sole purpose of access to my patient e-chart

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\*\*Signature Relationship Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name Date of Birth Email

***\*\* If patient is over 13 years of age, patient must sign for authorization AND provide their own email for access.*\*\***

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GIVE CONSENT FOR MY PARENT/GUARDIAN, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, TO HAVE ACCESS TO MY MEDICAL CHART AND INFORMATION CONTAINED IN THE MY KIDS CHART PATIENT PORTAL. I UNDERSTAND THAT MY CONSENT IS IN EFFECT UNTIL I SO CHOOSE TO REVOKE IT EITHER IN PERSON, VIA TELEPHONE OR IN WRITING.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PT SIGNATURE SOUTH SOUND PEDIATRICS WITNESS

Where a minor has right to consent to medical treatment, he or she also has right to control information related to treatment. A minor patient’s signature is required in order to release the following information: (1) conditions relating to the minor’s reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, any age sexually transmitted diseases (age 13 and older) (2) alcohol and/or drug use (age 13 and older) (3) mental health (age 13 and older).

For office use:

Picture ID checked: \_\_\_\_\_\_\_\_\_\_\_\_ (initials) Name of parent/guardian verified in chart \_\_\_\_\_\_\_\_\_\_ (initials)

Login in created: \_\_\_\_\_\_\_\_\_\_\_(date) \_\_\_\_\_\_\_(initials)