ASSOCIATE PEDIATRICS CLINIC
YYCPEDIATRICS.COM

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Associate Pediatrics

PATIENT INFORMATION:

Last Name: First Name: Middle Name:

Date Of Birth (DOB) MM/DD/YYY Gender: Male ◯ Female ◉

Health Care Number: Province:

Home Address:

City: Province: Postal Code:

Family Doctor:

PARENT/GUARDIAN INFORMATION:

Mother's Name: Occupation:

Primary Contact Number: Home ☐ Cell ☐ Work ☐

Secondary Contact Number: Home ☐ Cell ☐ Work ☐

Father's Name: Occupation:

Primary Contact Number: Home ☐ Cell ☐ Work ☐

Secondary Contact Number: Home ☐ Cell ☐ Work ☐

How would you like to be reminded of your child's upcoming appointments (Please check ONE option only)?

◯ Phone Call ◯ Email

◉ Text Message

When providing an email address on this form, please understand that it will be used for the purpose of receiving appointment notifications only and will not be a substitute for doctor advice, used for urgent matters, or sensitive information. Associate Clinic will not use your email for frivolous, commercial, or unapproved purposes. **If you want your pediatrician to communicate with you through our secure messaging system, please see the separate consent form.**

CONSENT FOR ROUTINE RELEASE OF INFORMATION:

To assist in the continuity of care for your child, often it is necessary to send clinical information to other health care providers. In order to provide for prompt transmission of this information, I (parent/guardian) consent to the release of any medical information on behalf of my child (patient noted above) my doctor deems necessary. I understand the reasons for the disclosure of this information, and that I may revoke my consent at any time by providing a signed, written statement to that effect.

I acknowledge that I have read, understand, and agree to the above.

I have read, understand, and agree to the Associate Pediatric Office Policies (attached to this clipboard)

PARENT NAME (Please Print):

SIGNATURE: **DATE (MM/DD/YYYY):**

PLEASE RETURN COMPLELTED FORM(S) TO RECEPTION