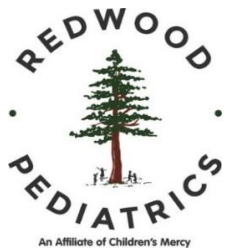

Last Name _____ First Name _____ MI _____

DOB _____ Gender: M / F

Parent/Guardian #1 _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Address _____ City _____ State_____ Zip _____

Parent/Guardian #2 _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Address _____ City _____ State_____ Zip _____

Who carries the insurance for this patient? _____DOB _____ SSN _____

Address (If different) _____ City_____ State _____ Zip _____

Preferred Pharmacy Name: _____ City: _____

Please initial the following items:

_____ I hereby consent that all information listed above is up to date and accurate.

_____ I hereby consent to medical treatment in our office today, including laboratory tests, immunizations, procedures, and physical exam.

_____ I hereby consent that the practice may disclose Health Information so that others may bill and receive payment from me, an insurance company, or a third party for the treatment and services received.

_____ I hereby consent that the practice can request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

_____ I hereby consent that medical providers at Redwood Pediatrics may discuss pertinent health information with outside medical providers as deemed necessary by those providers to provide medical care.

Signature of Legally Responsible Individual: _____ Date _____

Relationship: _____