WESTERN NEW YORK PEDIATRIC ASSOCIATES

PLEASE RETURN THIS PAGE AT YOUR FIRST VISIT

- **A parent must accompany child to the initial visit.***

______________________	______________________	__________
Parent or Guardian Name (Please Print)	Parent or Guardian Signature	Date

PLEASE LIST NAME AND **DATE OF BIRTH** FOR ALL CHILDREN:

______________________ ______________________

______________________ ______________________

______________________ ______________________

NOTICE: MANY TIMES SCHOOL NURSES CONTACT OUR OFFICE INQUIRING ABOUT IMMUNIZATION RECORDS AND THE DATE OF THE LAST ROUTINE (WELL) VISIT OF PATIENTS. WE WILL SHARE MINIMUM INFORMATION WITH THE SCHOOL UNLESS YOU ADVISE US NOT TO SHARE THIS MINIMUM PHI BY CHECKING BELOW.

DO NOT SHARE IMMUNIZATION RECORDS/WELL VISIT DATES WITH THE SCHOOL NURSE ☐ __________ Initials

NOTICE: THIS FORM AUTHORIZES OUR OFFICE TO LEAVE A MESSAGE AT THE TELEPHONE NUMBERS WE HAVE ON FILE. WE WILL LEAVE A MESSAGE AT YOUR HOME AND/OR WORK TELEPHONE NUMBER UNLESS YOU ADVISE US NOT TO BY CHECKING BELOW.

DO NOT LEAVE A MESSAGE AT MY HOME TELEPHONE # ☐ __________ Initials

DO NOT LEAVE A MESSAGE AT MY WORK TELEPHONE # ☐ __________ Initials

PLEASE LIST BELOW ANY PERSON(S), OTHER THAN PARENT(S)/LEGAL GUARDIAN(S) WHO IS PERMITTED TO SEEK MEDICAL CARE FOR YOUR CHILDREN. BY GIVING PERMISSION FOR THE PERSON(S) LISTED BELOW TO SEEK MEDICAL CARE FOR YOUR CHILDREN YOU ARE ALSO AUTHORIZING US TO SHARE PHI ABOUT YOUR CHILDREN WITH THEM. **THE PERSON MUST BE AGE 18 YEARS OR OLDER.**

______________________	______________________
NAME	RELATIONSHIP TO YOUR CHILDREN
______________________	______________________
NAME	RELATIONSHIP TO YOUR CHILDREN
______________________	______________________
NAME	RELATIONSHIP TO YOUR CHILDREN

*If your child comes in for a sick visit prior to the initial well visit, a parent must accompany for the initial well visit.