PATIENT REGISTRATION (under 18)

Patient's Name: _____
(First) (Middle) (Last)

Date of Birth: _____ Gender (check one): Sex: M _____ F _____

Parent or Guardian Name(s): _____

Address: _____
(City) (State) (Zip)

Home Phone #: _____ Mom/Dad Cell Phone #: _____

Responsible Party Address (if different than above):

_____

Responsible Party Employer: _____ Work Phone #: _____

Employer's Address: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

How did you hear about our clinic: _____

Authorization to Discuss Health Information: I hereby authorize medical providers and personnel of Northwest Family Clinics to discuss my protected health information with the named individual(s) below. By leaving this area blank, providers and personnel will not share my protected health information.

Relationship	**Name**	**Phone #**
_____	_____	_____
_____	_____	_____

SIGNATURE_____ **DATE:** _____

If you are signing on behalf of the patient, please state your relationship_____