GPM Pediatrics, PC

Date_____

Patient Registration

Patient's Full Name	Date of Birth	Sex (circle one) **Male Female**
Ethnicity: □ Asian □ Black or African American □ Hispanic □ White □ American Indian or Alaska Native □ Native Hawaiian or other Pacific Islander		

Physical/Permanent Address		
Home Phone	Mailing Address (If different from Physical Address)	
Email Address	Cell Phone	Social Security Number
Employers' Name and Address		
Work Phone Number		Occupation

This is my authorization and consent for the below named person or persons to act on my behalf in regards to receiving information from or making requests to GPM Pediatrics, PC. Please initial all that apply (signature at bottom of page is also required).

_____ Request/Receive Medical Records

_____ Full access to Patient Portal Account

_____Request Prescriptions

_____ Request prescriptions (excluding controlled substances, e.g. Antibiotics)

_____ Request controlled substance prescriptons (e.g. Adderol, Focalin, etc.)

Person(s) authorized for the activities initialed above:

Name _____ Relationship to Patient _____

_____ _____

_____

Patient Signature Date