Patient Portal Registration Form

Parent/Guardian's Name: _____
(Or Patient if 16 years or older) (First) (Middle) (Last)

Email Address: _____
(Please Print)

Primary Contact Number:_____ **Primary Number Is**: Home # ☐ Cell # ☐ Alternate # ☐
(Please Mark One)

PLEASE NOTE: State and Federal privacy laws require a written release from all patients 16 years of age and older before we can post their records on the portal for parents to view.
(For Patients 16yrs or older, please request a separate form for the patient to fill out if they wish to grant parental access.)

Children's Names and Dates of Birth

(First, Middle, Last) (mm/dd/yyyy)

Patient's Name:_____ Date of Birth: _____

Patient's Name:_____ Date of Birth: _____

Patient's Name:_____ Date of Birth: _____

Patient's Name:_____ Date of Birth: _____

Patient's Name:_____ Date of Birth: _____

Signature:_____ **Date**: _____

FOR STAFF USE ONLY:
I confirmed Parent/Guardian identity using the following ID: _____
Staff Member Name: _____